Prepaid Inpatient Health Plan (PIHP) Coordinated System of Care (CSoC)

Systems Companion Guide

October 2015
Version 1.0

Prepaid Inpatient Health Plan (PIHP) Coordinated System of Care (CSoC) Systems Companion Guide

The Department of Health and Hospitals (DHH) will provide maintenance of all documentation changes to this Guide using the Change Control Table as shown below.

Change Control Table

Author of Change	Sections Changed	Description	Reason	Date
Andrea Hollins/ Kerri Capello	Version 1.0			10/11/2015
Kerri Capello	Appendix G	Updated Provider Types & Provider Specialties	DHH Provider Types & Provider Specialties missing from grid	10/13/2015
Kerri Capello	Appendix J	Removed paragraph under LTC CSoC File layout	Isn't applicable to file	10/13/2015
Kerri Capello	Appendix E	Removed the word Interim.	Reporting denied claims in encounter is not included in CSoC contract. Denied claims will be reported in the monthly claims report for this contract.	10/14/2015
Jacques Kado	Appendix J	Updated the LTC LBHP/CSoC PIHP Segment Layout	Provided additional clarification	10/21/2015
Andrea Hollins	Appendix L	Added the Lookup Taxonomy Table	Magellan requested the table be added	10/29/15
Andrea Hollins	Section 7	Removed Codes – H0018, T2048, S5145, and H2013	Codes are not covered services	10/29/15
Andrea Hollins	Section 2	Reporting Interest Payment	Explanation of how interest is to be reported	11/2/15

Prepaid Inpatient Health Plan (PIHP) Coordinated System of Care (CSoC) Systems Companion Guide

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Overview

Introduction

The Department of Health and Hospitals (DHH) is an administrative department within the Executive Branch of State government in Louisiana. The administrative head of DHH is the Secretary, who is appointed by the Governor. The mission of DHH is to protect and promote health and ensure access to medical, preventive, and rehabilitative services for all citizens of the State of Louisiana (State). DHH is dedicated to fulfilling its mission through direct provision of quality services, development and stimulation of services for others, and utilization of available resources in the most effective manner.

DHH is comprised of the Bureau of Health Services Financing/Medical Vendor Administration (BHSF/MVA), Office of Behavioral Health (OBH), the Office for Citizens with Developmental Disabilities (OCDD), the Office of Aging and Adult Services (OAAS), and the Office of Public Health (OPH). Under the general supervision of the Secretary, these principal offices perform the primary functions and duties assigned to DHH. DHH, in addition to the program offices, has an administrative office (Office of the Secretary), a financial office (Office of Management and Finance), and various bureaus and boards. The Office of the Secretary is responsible for establishing policy and administering operations, programs, and affairs.

BHSF/MVA and the Office of Behavioral Health (DHH-OBH) share oversight of the Coordinated System of Care (CSoC). The CSoC is a research-based model that is part of a national movement to develop family and youth-driven care and keep children with severe behavioral health needs at home, in school, and out of the child welfare and juvenile justice system. The CSoC also creates partnerships with public and private providers to form a multi-agency, multi-disciplinary system of care. The system of care model involves collaboration among agencies, families, and youth for the purpose of improving access and expanding the array of coordinated community-based, culturally and linguistically competent services for CSoC youth and families.

This System Companion Guide, along with the current contract between BHSF/MVA and the Prepaid Inpatient Health Plan (PIHP), provides assistance to the PIHP with requirements for submitting and receiving encounter data.

DHH, based on Federal Guidelines, requires the PIHP to report encounters for all CSoC enrolled recipients. Reporting of these encounters must include all paid encounters for services provided to CSoC recipients who receive services under the CSoC contract.

The PIHP will be required to submit encounters to the Fiscal Intermediary (FI) using HIPAA compliant Provider-to-Payer-to-Payer Coordination of Benefits (COB) 837I (Institutional) and 837P (Professional) transactions. DHH has provided as quick references in Appendix A Definitions of Terms and Appendix B Frequently Asked Questions.

Encounter Definition

Encounters are records of medically related services rendered by the PIHP provider to Medicaid enrollees eligible for contracted services with the PIHP on the date of service. It includes all services for which the PIHP has any financial liability to a provider. An encounter is comprised of the procedures(s) and/or service(s) rendered during the contract. The PIHP must report all paid claims processed under the PIHP Contract as an encounter. Covered services under this contract include, but are not limited to the following:

- Mental Health Hospitals (free standing or distinct part psychiatric unit)
- Mental Health Clinics
- Physicians, Advance Practice Registered Nurses (APRN)
- Licensed Psychologists
- Licensed Clinical Social Workers
- Licensed Professional Counselors
- Licensed Marriage & Family Therapists
- Licensed Addiction Counselors
- Substance use and Alcohol use Centers
- Behavioral Health Rehabilitation Agencies or Providers
- Therapeutic Group Homes
- Family Support Organizations
- Transition Coordination Agencies
- Respite Care Services Agencies
- Crisis Receiving Centers
- Behavioral Health Rehabilitation Provider Agencies
- Federally Qualified Health Centers (FQHC)
- Rural Health Centers (RHC)
- HCBS 1915c Waiver Services for Children

Purpose of Encounter Collection

The purposes of encounter data collection are as follows:

Contract Requirements

The PIHP must comply with encounter reporting requirements in accordance with the ASC X12 Standards Implementation (837IG) and the PIHP Systems Companion Guide, including payment withholding provisions and penalties for non-reporting, untimely reporting, or inaccurate reporting.

For complete and accurate encounter data submissions, the PIHP shall submit all encounter data at least weekly, and no later than the week following the week in which they were processed and approved/paid, including encounters reflecting a zero dollar amount ($0.00) and claims in which the PIHP has a capitation arrangement with a provider.

Quality Management and Improvement

The CSoC program operated by the PIHP is a Medicaid program partially funded by CMS. The PIHP is required to collect and report performance measures (PM) data that demonstrates adherence to clinical practice and/or improvement in patient outcomes. These measures as defined by DHH, are reflected in the current PIHP contract. DHH will use encounter data to evaluate the performance of the PIHP and to audit the validity and accuracy of the reported measures.

Continuous Quality Improvement Plan for Oversight and Assessment of Medicaid Managed Care

According to the Balanced Budget Act (BBA), a written quality strategy plan is required to serve as the guiding principles for assessing the quality, effectiveness, and efficiency of services rendered to Medicaid enrollees. The goal of the quality strategy plan is to purchase the best value health care and services for DHH beneficiaries, to improve access to services for underserved and vulnerable beneficiary populations, and to protect them from substandard care. The objectives of the plan are to assess, monitor, and measure the improvement in health care and behavioral health services provided directly or through referrals to Medicaid CSoC beneficiaries, and to ensure the accuracy in claim payments for services rendered.

Continuous quality improvement focuses on measuring and improving the quality of the encounter data available to DHH. Data from the PIHP will continue to undergo data quality checks beyond the minimum criteria used in the edit process.

Implementation Date

Within sixty (60) days of operation, the PIHP's Systems shall be ready to submit encounter data to DHH's FI in a HIPAA compliant Provider-to-Payer-to-Payer COB format. Prior to submitting production encounters, the PIHP will test system changes using the state's FI submitter self-test system.

DHH Responsibilities

DHH is responsible for administering the Coordinated System of Care Program. Administration includes data analysis, feedback to the PIHP, ensuring data confidentiality, and the contents of this PIHP Systems Companion Guide. Written questions or inquiries about the Guide must be directed to:

Name: Bill Perkins Deputy Medicaid Director	**Name:** Kerri Capello & Andrea Hollins
Telephone:225-342-1435	**Telephone:** 225-342-4981
E-mail: Bill.Perkins@la.gov	**Email:**Kerri.Capello@la.gov;. Andrea.Hollins@la.gov

DHH is responsible for the oversight of the PIHP contract and PIHP activities. DHH's responsibilities include coordination with Medicaid's FI on the development and production of the Systems Companion Guide, dissemination of the Systems Companion Guide to the PIHP, the initiation and ongoing discussion of data quality improvement with the PIHP, and facilitation of PIHP training. DHH-OBH will notify the PIHP of all updates and provide the PIHP with the most current version of the Systems Companion Guide (as it is revised throughout the contract).

DHH reserves the right to revise the PIHP Systems Companion Guide at any time during the contract.

Fiscal Intermediary (FI) Responsibilities

Molina is under contract with DHH to provide Louisiana Medicaid Management Information System (LMMIS) services including the acceptance of electronic encounter and claim reporting from the PIHP. DHH's FI will be responsible for accepting, editing and storing PIHP 837 claims data. The FI will also provide technical assistance to the PIHP during the 837 testing process.

The PIHP will receive a listing of Medicaid eligible recipients at the beginning of each month and daily files for updates in a proprietary format.

X12 Reporting

If the file contains syntactical errors, the segments and elements where the error occurred are reported in a 999 Functional Acknowledgement. The TA1 report is used to report receipt of individual interchange envelopes that contain corrupt data or an invalid trading partner relationship.

After claim adjudication, an ANSI ASC X12N 835 Remittance Advice (835) will be delivered to the PIHP if requested by the PIHP. The PIHP must prearrange for receipt of 835 transactions.

Proprietary Reports

The FI will also provide the PIHP with a monthly financial reconciliation report. The file layout can be found in Appendix D of this Guide.

These files include:

- Encounter Claims Summary
- Encounter Edit Disposition Summary
- Edit Code Detail
- 820 File
- SMO-O-005 and SM-W-010

Prepaid Inpatient Health Plan (PIHP) Responsibilities

The PIHP is responsible for submitting accurate and complete encounter data.

The PIHP must evaluate the adequacy of, and revise if necessary, the data collection instruments and processes being used by its providers. With regard to provider identification, the PIHP is responsible for ensuring that the appropriate NPI, taxonomy, and 9-digit zip code are submitted in each transaction.

The PIHP is expected to investigate the findings of encounter denials and be prepared to explain the underlying reasons for the identified data quality issue(s). As data issues are identified, the PIHP must document and track all denials including a listing of the issues, any action steps, responsible parties, and projected resolution dates. This tracking document, and successive updates, will be provided to DHH upon request.

The PIHP shall be able to transmit, receive and process data in HIPAA-compliant or DHH specific formats and/or methods, including, but not limited to, secure File Transfer Protocol (FTP) over a secure connection such as Virtual Private Network (VPN), that are in use at the start of the Systems readiness review activities.

On a monthly, quarterly, and yearly basis, the PIHP is required to provide DHH with PIHP Generated Reports as addressed in Appendix E of this Guide.

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Transaction Set Supplemental Instructions

Introduction

The HIPAA transaction and code set regulation requires that covered entities exchanging specified transactions electronically must do so using the appropriate ANSI ASC X12 EDI formats. Further, HIPAA has defined how each of these transactions is to be implemented. Implementation instructions are contained in detailed instruction manuals known as implementation guides (IGs) located on the CMS website. The IGs provide specific instructions on how each loop, segment, and data element in the specified transaction set is used.

The 837 formats used for DHH-OBH are the 837 Institutional (837I) and 837 Professional (837P) Provider-to-Payer-to-Payer Coordination of Benefits (COB) Model, as defined in the HIPAA IGs.

The ASC X12 (837 IGs) contain most of the information needed by the PIHP to complete this mapping. The PIHP Systems Companion Guide contains the remaining information.

The PIHP shall create their 837 transactions for DHH using the HIPAA IG Version 5010. On January 16, 2009, HHS published final rules to adopt updated HIPAA standards; these rules are available at the Federal Register.

January 1, 2012, HHS adopted X12 Version 5010 for HIPAA transactions for all covered entities.

The ANSI ASC X12N 837 (Healthcare Claim Transactions – Institutional, Professional) Companion Guide is intended for trading partner use in conjunction with the ANSI ASC X12N National Implementation Guide.

The ANSI ASC X12N Implementation Guides can be accessed at http://www.wpc-edi.com/content.

Transformed Medicaid Statistical Information System (T-MSIS)

Introduction

Effective November 1, 2014, DHH, based on the Center for Medicare and Medicaid Services (CMS) mandate, is required to report on a monthly basis, ALL data elements submitted via 837 transaction as submitted by the PIHP. Reporting of the data elements will be done thru Transformed Medicaid Statistical Information System (T-MSIS)

The PIHP is expected to fully comply with T-MSIS system changes and testing. The PIHP is required to fully populate 837 data elements in accordance with the existing 5010 Implementation Guide.

The PIHP is required to perform testing thru the FI of Tier 1 and Tier 2 data elements in 2 Phases. Upon approval from the FI, the SMO must integrate the approved data elements into their system within 30 days of notification by and as designated by DHH.

Tier 1 Data Elements

Tier 1 is comprised of 143 data elements that are required to be reported by DHH, thru its FI, to CMS.

Phase I

The PIHP is required to utilize the 837 Mapping layouts (to test data elements currently being captured by the SMO but are not being sent to the FI.

Phase II

The PIHP is required to utilize the 837 Mapping layouts to integrate data elements not currently being captured by the SMO and sent to the Medicaid FI.

The FI and/or DHH will provide feedback regarding the status of the data elements tested to the PIHP via the MCO T-MSIS Test Tracking Document.

Feedback will include comment(s) for data element(s) that FAILED the test. The PIHP must correct, provide the reason for the FAILED data elements, and resubmit the corrected data elements to the FI (within the timelines designated by DHH-OBH) for re-testing until approval of FAILED Data Elements is received from the FI.

Data elements that receive “PASS” status from the FI will receive approval and/or comments from DHH and/or FI to integrate the data elements into the SMO’s System.

Tier 2 Data Elements

CMS has advised DHH that Tier 2 Data Elements will be addressed in the Operational stage of T-MSIS.

DHH will continue to provide additional information regarding T-MSIS as it becomes available.

NOTE: **Testing for T-MSIS has been completed, and T-MSIS will move into production pending CMS approval Fiscal Intermediary (FI) Companion Guides and Billing Instructions**

FI Companion Guide and Billing Instructions

Introduction

Molina, as DHH's FI, provides Electronic Data Interchange (EDI) services. The EDI validates submission of ANSI X12 format(s). If the file contains syntactical error(s), the segments and elements where the error(s) occurred are reported in a 999 Functional Acknowledgement. The TA1 report is used to report receipt of individual interchange envelopes that contain corrupt data or an invalid trading partner relationship. The FI HIPAA Companion Guides can be found at www.lamedicaid.com or www.lmmis.com. Select HIPAA Billing Instructions and Companion Guides from the left hand menu.

DHH Supplemental Instructions

DHH requires the PIHP to submit the Provider-to-Payer-to-Payer COB Model of the 837. There can be multiple COB loops. The loops in the 837 HIPAA implementations that are used to convey information regarding adjudication are the 2320 (Other Subscriber Information), 2330B (Other Payer information) and 2430 (Service Line Adjudication Information). In the first set of COB loops, the PIHP will be required to include information about the PIHP provider claim adjudication. In the first set of COB data, the PIHP shall place their unique DHH carrier code in loop 2330B, NM109. If there is Medicare TPL, the PIHP shall place Medicare's unique DHH carrier code, 999999, in the second set of COB loops. The PIHP shall provide DHH with any third-party payments, in subsequent COB loops. The PIHP must include the DHH carrier code of the other payer in loop 2330B NM109. There can be only one single subsequent loop per unique payer.

PIHP and Medicare Unique DHH Carrier Code Assignment

Plan Name: PIHP (Magellan)	Assigned Carrier Code: 999996
Medicare	Assigned Carrier Code: 999999

Batch Submissions

The PIHP may submit batch encounters, up to 99 files per day. Batch encounters maximum recommended file size is 20,000 per file (maximum of 100,000 per week). Files must be ASC X 12 N 837 format compliant.

The FI's weekly cutoff for accepting encounters is Thursday at 12:00 (noon) CDT. Encounters received after the deadline will be processed during the next week's cycle.

Split Billing Claims

The PIHP may refer to the Hospital Services Manual for DHH policy on split billing located on the www.lamedicaid.com website.

COB Model of 837 with TPL

In 837 files, TPL is sent in the Coordination of Benefits (COB) set of segments. For Inpatient records, the TPL data should be sent at the Claim-Doc level; for all other types of records, if the TPL data is available at the Service-Line level then it should be sent at the Service-Line level.

Part of the COB data is always at the ClaimDoc level; it begins with the SBR segment of Loop 2320, it includes segments in Loop 2330A and this part ends with segments from Loop 2330B.

- For Inpatient records, all of the TPL data will be sent (at the Claim Doc level) in the Loop 2320 through Loop 2330B segments.
- For non-Inpatient records where there is Service-Line level TPL data, in addition to the Claim- Doc level COB data segments, the Service-Line level specific TPL data should be sent in the Loop 2430 segments.

When TPL data is being reported at the Claim-Doc level:

- The LA Medicaid 6-digit TPL Carrier Code value is sent in Loop 2330B NM109;
- The TPL amount paid is sent in the Loop 2320 AMT*D segment;
- The TPL payment date is sent in the Loop 2330B DTP segment; and
- Any Claim Level Adjustments are sent in Loop 2320 CAS segments.

When TPL data is being reported at the Service-Line level:

- The LA Medicaid TPL Carrier Code value is sent in both Loop 2330B NM109 and in Loop 2430 SVD01;
- The TPL amount paid is sent in Loop 2430 SVD02;
- The TPL payment date is sent in the Loop 2430 DTP segment; and
- Any Line Adjustments are sent in Loop 2430 CAS segments.

Identifying Atypical Providers

A-typical providers may not be assigned an NPI. The PIHP is to follow the instructions below when submitting any of the documents in **Appendix G**, as well as, encounters for this category of providers.

If a provider has a NPI, the PIHP must send the NPI in Loop 2010AA NM109 (the typical place to send the Billing Provider's NPI in 837s). If the provider has a LA Medicaid Legacy Provider ID, send that number in Loop 2010BB REF*G2.

File Splitting Criteria

Encounter files must be submitted using the following file extension criteria.

Transaction.	Claim Type	Name	File Extension	Sample file name
837P	09	Durable Medical Equip. Provider Type=40	DME	H4599999.DME
837P	04	Physician, Pediatric Day Health Care Professional Identify all 837P claims including EPSDT services, and excluding Rehab.	PHY	H4599999.PHY
837P	05	Rehabilitation Provider Type=65, 59	REH	H4599999.REH
837P	07	Ambulance Transportation EMT: Provider Type=51	TRA	H4599999.TRA
837P	08	Non-Emergency Medical Transportation NEMT Provider Type = 42	NAM	H4599999.UB9
837I	01 & 03	Hospital IP/OP Inpatient: Identify by Place of Service: 1st 2 digits of Bill Type =11 or 12. Outpatient Identify by Place of Service: 1st 2 digits of Bill Type = 13, 14 or 72	UB9	H4599999.UB9
NCPDP Batch	12	NCPDP Batch Pharmacy Provider Type = 26		H4599999.NCP
837I	06	Home Health Bill Type 1st 2 digits of Bill Type=32.	HOM	H4599999.HOM

BHT06

The BHT06 is used to indicate the type of billed service being sent: fee-for-service (claim) or encounter.

- Use a value of CH when the entire ST-SE envelop contains FFS Claims.
- Use a value of RP when the entire ST-SE envelope contains encounters. RP is used when the transaction is being sent to an entity (usually not a payer or a normal provider payer transmission intermediary) for purposes other than adjudication of a claim.
- If the RP value is not used, either the entire batch of encounters will be rejected, or the batch will be processed as claims, which will result in the denial of every claim.

Accepting and Storing Encounters

DHH's FI will be responsible for accepting, editing and storing PIHP 837 encounter data.

PIHP Internal Control Number (ICN)

A unique Plan ICN is to be populated for each service line in Loop 2400 REF*6R.

The plan ICN length can be up to 30 characters. The ICN shall be modified to contain a 4-digit prefix as follows:

Character 1: Claim submission media type. Standard types would be 'P' to indicate a paper, 'E' to indicate an electronic claim, and 'W' to indicate a claim submitted over a web portal. If other types are submitted, the PIHP must provide a data dictionary.

Character 2: Claim paid If the claim was paid by the PIHP this character position should have a 'P'.

Character 3–4: Vendor information. The PIHP shall provide a data dictionary that indicates which vendor or organization the claim was paid by. As vendors are changed, the PIHP is required to provide an update to the data dictionary.

Billing Provider Patient Control Number

The Billing Provider Patient Control Number (PAT-Ctrl-No) is to be populated in Loop 2300 CLM01.

The PIHP must echo the Provider Patient Control number from the claim in CLM01 segment of the 837.

The following EDI Delimiters cannot be part of a Data Element (field) value. If any of the EDI Delimiters are part of a field value from a paper Claim record, the Encounter record value should substitute a <space> Character where the Delimiter Character was located.

CHARACTER	NAME	DELIMITER
*	Asterisk	Data Element Separator
^	Carat	Repetition Separator
:	Colon	Component Element Separator
~	Tilde	Segment Terminator

Paper Claims submitted without the Patient Control Number shall be submitted using "NOT SUPPLIED" in the CLM01 field.

Financial Fields

The financial fields that DHH requests the PIHP to report include:

- Header and Line Item Submitted Charge Amount
- Header and Line Item PIHP Paid Amount
- Header and Line Item Adjustment Amount

Header and Line Item Submitted Charge Amount — The PIHP shall report the provider's charge or billed amount. The value may be "$0.00" if the PIHP contract with the provider is capitated and the PIHP permits zero as a charged amount. If the submitted charge is billed as "$0.00", the MMIS will calculate the paid amount as zero since DHH pays the lesser of the submitted charge or the calculated fee amount. A value other than "$0.00" must be submitted when the provider bills on a FFS basis.

Header and Line Item PIHP Paid Amount — If the PIHP paid the provider for the service, the Paid Amount shall reflect the amount paid. If the service was not covered by the PIHP or was covered under a sub-capitation arrangement, "$0.00" is the appropriate Paid Amount. This amount is stored in the encounter as a Third Party Liability (TPL) amount.

Header and Line Item Adjustment Amount — If the Paid Amount reflects any adjustments to the Submitted Line Item Charge Amount, the adjustment amounts must be reported. Any time the charge amount does not equal the paid amount, the PIHP is required to report both the Adjustment Amount and the adjustment reason code (found at http://www.wpc-edi.com/codes/). The adjustment amounts and reason codes are critical to the correct pricing of the encounter in the MMIS.

Claim Received Date

The PIHP is required to submit the Plan's Claim Received Date in 837-P and 837-I encounter data.

The Claim Received Date will be sent in Loop 2300 in the REF*D9 Segment using date format yyyymmdd.

For Original Encounter records, the Claim Received Date value should be the date that the PIHP received the Claim record from the Billing Provider.

For Adjustment Encounter records, if the Adjustment was initiated by the Billing Provider, then the Claim Received Date value should be the date that the PIHP received the Claim Adjustment record from the Billing Provider. If the Adjustment was initiated by the PIHP, then the Claim Received Date value should be the same as the Claim Paid Date of the Adjustment.

For Void Encounter records, if the Void was initiated by the Billing Provider, then the Claim Received Date value should be the date that the PIHP received the

Claim Void record from the Billing Provider. If the Void was initiated by the PIHP, then the Claim Received Date value should be the date that the PIHP processed the Void record.

If a void or adjustment is requested by DHH or Molina, the original PIHP Claim received date would remain.

Claim Paid Date

Claim paid date is defined as the date the payment is released to the provider.

The PIHP is required to submit the Plan's Claim Paid Date in 837-P and 837-I encounter data.

For Inpatient records, the Claim Paid Date will be sent in Loop 2330B in the DTP*573 Segment.

For non-Inpatient records, the Claim Paid Date will be sent in Loop 2430 in the DTP*573 Segment.

Interest Paid Amount

Interest Paid by the PIHP is required to be submitted in the Claim Interest Amount along with the Paid Date in 837P and 837I Encounter Data.

In the Claim Interest set of COB Loops, a value in INT996 format will be used (instead of using the PIHP unique DHH Carrier Code – 999996) where the last digit is the same last digit from the PIHP contractor's unique DHH Carrier Code value.

For Inpatient records, in the Claim Interest set of COB Loops, the Interest Paid Amount will be sent in CAS03 of Loop 2320 using CAS02 value 225. The interest Paid Amount will also be sent in AMT02 of the Loop 2320 AMT*D segment. The Interest Paid Date will be sent in Loop 2330B DTP*573 Segment.

For non-Inpatient records, in the Claim Interest set of COB Loops, the Interest Paid Amount will be sent in CAS03 of Loop 2430 using CAS02 value 225. The Interest Paid Amount will also be sent in Loop 2430 SVD02. The Interest Paid Date will be sent in the Loop 2430 DTP*573 Segment.

Professional Identifiers

The PIHP is required to submit the provider's NPI, Taxonomy Code and 9-digit zip code in each encounter. If the last four digits of the zip code are unknown the PIHP may substitute "9999".

Supplementation of CMS-1500 and UB-04

Certain information may be required that is not routinely present on the UB-04 or CMS-1500. In these circumstances, the PIHP must obtain valid medical records to supplement the UB-04 or use logic from the paper claim to derive the required additional information for the 837 transactions.

Category II CPT Codes

DHH requires the use of applicable Category II CPT Codes or HCPCS Level II G Codes for performance measurement. These codes will facilitate data collection about the quality of care rendered by coding certain services and test results that support nationally established performance measures. In conjunction with the Category II CPT Codes, the PQRI quality-data codes (QDCs) follow current rules for reporting other CPT and HCPCS codes.

On the ASC X12N 837 professional health care claim transaction, Category II CPT and HCPCS Level II codes are submitted in the SV1 "Professional Service" Segment of the 2400 "Service Line" Loop. The data element for the procedure code is SV101-2 "Product/Service ID." Note that it is also necessary to identify in this segment that you are supplying a Category II CPT/HCPCS Level II G-code by submitting the "HC" code for data element SV101-1. Necessary data elements (or fields) include, but are not necessarily limited to, the following:

- Date of service;
- Place of service;
- PQRI QDC(s), along with modifier (if appropriate);
- Diagnosis pointer;
- Submitted charge ($0.00 shall be entered for PQRI codes);
- Rendering provider number (NPI).

The submitted charge field cannot be left blank. The amount of $0.00 shall be entered on the claim as the charge.

Transaction Type

The following tables provide guidance on the use of 837s. This guidance is subject to change. Please note that the following tables contain DHH provider types and are outlined consistent with the services manual included in the PIHP contract.

At present, the following provider types use 837I:

Provider Type	Description
44	Home Health Agency
54	Ambulatory Surgical Center

Provider Type	Description
55	Emergency Access Hospital
59	Neurological Rehabilitation Unit (Hospital)
60	Hospital
64	Mental Health Hospital (Free-Standing)
65	Rehabilitation Center
69	Hospital – Distinct Part Psychiatric Unit
76	Hemodialysis Center
77	Mental Health Rehabilitation
80	Nursing Facility

The following provider types use 837P:

Provider Type	Description
01	Fiscal Agent - Waiver
02	Transitional Support - Waiver
03	Children's Choice - Waiver (in-state only)
04	Pediatric Day Health Care (PDHC) facility
06	NOW Professional (Registered Dietician, Psychologist, Social Worker)
07	Case Mgmt - Infants & Toddlers (in-state only)
08	Case Mgmt - Elderly (in-state only)
11	Shared Living - Waiver (in-state only)
12	Multi-Systemic Therapy (in-state only)
13	Pre-Vocational Habilitation (in-state only)
14	Adult Day Habilitation - Waiver (in-state only)
15	Environmental Accessibility Adaptation - Waiver (in-state only)
16	Personal Emergency Response Systems - Waiver
17	Assistive Devices - Waiver
19	Doctor of Osteopathy (DO) and Doctors of Osteopathy(DO) Group
20	Physician (MD) and Physician (MD) Group
22	Waiver Personal Care Attendant
23	Independent Lab
24	Personal Care Services (LTC/PCS/PAS) (in-state only)
25	Mobile X-Ray/Radiation Therapy Center
27	Dentist and Dental Group
28	Optometrist and Optometrist Group
29	EarlySteps and EarlySteps Group (in-state only)
30	Chiropractor and Chiropractor Group
31	Medical or Licensed Psychologist

32	Podiatrist and Podiatrist Group
34	Audiologist
35	Physical Therapist
37	Occupational Therapist
38	School-Based Health Center (in-state only)
39	Speech/Language Therapist
40	DME Provider (out-of-state for crossovers only)
41	Registered Dietician
42	Non-Emergency Medical Transportation (in-state only)
43	Case Mgmt - Nurse Home Visit - 1st Time Mother (in-state only)
44	Home Health Agency (in-state only) (for Waiver Services ONLY)
45	Case Mgmt - Contractor (in-state only)
46	Case Mgmt - HIV (in-state only)
47	Case Mgmt - CMI
48	Case Mgmt - Pregnant Woman
49	Case Mgmt - DD
50	PACE Provider
51	Ambulance Transportation
54	Ambulatory Surgical Center (in-state only)
61	Venereal Disease Clinic
62	Tuberculosis Clinic
65	Rehabilitation Center
67	Prenatal Health Care Clinic
68	Substance Abuse and Alcohol Abuse Center
70	LEA and School Board (EPSDT Health Services) (in-state only)
71	Family Planning Clinic
72	Federally Qualified Health Center (in-state only)
73	Licensed Clinical Social Worker (LCSW)
74	Mental Health Clinic
75	Optical Supplier (in-state only)
77	Mental Health Rehabilitation (in-state only)
78	Nurse Practitioner and Nurse Practitioner Group
79	Rural Health Clinic (Provider Based) (in-state only)
81	Case Mgmt - Ventilator Assisted Care Program
82	Personal Care Attendant - Waiver (in-state only)
83	Respite Care (Center Based)- Waiver (in-state only)
84	Substitute Family Care - Waiver (in-state only)
87	Rural Health Clinic (Independent) (in-state only)
89	Supervised Independent Living - Waiver (in-state only)
90	Nurse-Midwife
91	CRNA or CRNA Group

93	Clinical Nurse Specialist
95	American Indian / Native Alaskan "638" Facilities
97	Adult Residential Care
98	Supported Employment - Waiver (in-state only)
99	Greater New Orleans Community Health Connection (in-state only)
AA	Assertive Community Treatment Team (ACT)
AB	Prepaid Inpatient Health Plan (PIHP)
AC	Family Support Organization
AD	Transition Coordination (Skills Building)
AE	Respite Care Service Agency
AF	Crisis Receiving Center
AG	Behavioral Health Rehabilitation Provider Agency
AH	Licensed Marriage & Family Therapist (LMFT)
AJ	Licensed Addiction Counselors (LAC)
AK	Licensed Professional Counselors (LPC).
AL	Community Choices Waiver Nursing
AM	Home Delivered Meals
AN	Caregiver Temporary Support

3

Encounter Edit Code(s) Disposition Logic

Introduction

DHH has modified edits for encounter processing. In order to ensure DHH has the most complete data for rate setting and data analysis, the PIHP is required to correct all repairable edit codes when applicable and to submit corrected encounters to the FI for reprocessing.

Encounter Edits

The FI's responsibility is to receive and process quality Encounter Data as submitted by the PIHP. To accomplish this, the Medicaid Management Information System applies a series of Edits based on claim type and/or procedure codes. Edit disposition are subject to change. Each edit has been assigned one (1) of the following Dispositions:

- Educational Edits
- Deny Edits
    - Repairable - Under Limited Circumstances Deny
    - Deny - Repairable
    - Deny- Not Repairable

Educational Edits

Encounters set to the "Educational" (E) disposition are "informational only", and are in an approved status. The PIHP does not need to make a correction to the encounter for edits with this disposition. DHH may determine that the disposition of certain Educational Edits may/will be temporary in some instances for a specified period of time. In these instances, the PIHP will be notified when the disposition of an edit changes and will be provided additional instructions regarding the change.

Deny-Repairable Edits

Encounters that are set to the "Deny-Repairable" disposition are encounters that must be corrected. The PIHP is required to correct these encounters and resubmit them to the FI for processing.

A list of Deny Edits – Repairable can be found at the end of this section. The list of repairable deny edits are subject to change and may not be limited to the edits identified at the end of this section.

Encounters that are set to the "Deny-Not Repairable" disposition are encounters that are not correctable. The PIHP may not resubmit these encounters to the FI for processing.

Deny-Not Repairable Edits

A list of Deny-Not Repairable Edits can be found in Appendix F of this Guide. The list of non-repairable deny edits are subject to change and may not be limited to the edits identified at the end of this section.

System logic for some edits will be added to the guide upon update. The PIHP may request in writing the system logic for edits not included in this Guide.

Encounter Correction Process

DHH's FI will send edit code reports to the PIHP the day after they are produced by the MMIS adjudication cycle via the web.

Resubmissions

The PIHP may make corrections to the service line(s) to which a repairable edit code was applied.

If an encounter is denied in its entirety, the PIHP may resubmit the encounter once it has been corrected.

The table below represents the edit codes that may be corrected by the PIHP.

EDIT CODE	EDIT DISPOSITION – DENY (REPAIRABLE OR REPAIRABLE UNDER LIMITED CIRCUMSTANCES)[1] EDIT DESCRIPTION
001	INVALID CLAIM TYPE MODIFIER
002	INVALID PROVIDER NUMBER
003	INVALID RECIPIENT NUMBER
005	INVALID STATEMENT FROM DATE
006	INVALID STATMENT THRU DATE
007	SERVICE THRU DATE LESS THAN SERVICE FROM DATE
008	SERVICE FROM DATE LATER THAN DATE PROCESSED

[1] These denials may be corrected or corrected only in some instances

EDIT CODE	EDIT DISPOSITION – DENY (REPAIRABLE OR REPAIRABLE UNDER LIMITED CIRCUMSTANCES)[1] EDIT DESCRIPTION
009	SERVICE THRU DATE GREATER THAN DATE OF ENTRY
012	ORIGINAL CLAIM WITH AN ADJUSTMENT OR VOID REASON CODE
013	ORIGINAL CLAIM WITH AN ADJUSTMENT OR VOID ICN
015	ACCIDENT INDICATOR MUST BE Y N SPACE
016	ACCIDENT INDICATOR NOT Y N OR SPACE
017	EPSDT INDICATOR NOT Y N OR SPACE
023	RECIPIENT NAME IS MISSING
024	BILLING PROVIDER NUMBER NOT NUMERIC
026	TOTAL DOCUMENT CHARGE MISSING OR NOT NUMERIC
028	INVALID MISSING PROCEDURE CODE
040	ADMISSION DATE MISSING OR INVALID
043	INVALID ATTENDING PHYSICIAN
045	PATIENT STATUS CODE INVALID OR MISSING
046	PATIENT STATUS DATE MISSING OR INVALID
047	PATIENT STATUS DATE GREATER THAN THRU DATE
055	ACCOMMODATION/ANCILLARY CHARGE MISSING OR INVALID
063	THE TOTAL HOSPITAL CHARGE IS NOT NUMERIC
064	THE NET BILLED AMOUNT IS NOT NUMERIC
065	THE SIGNATURE INDICATOR MUST BE Y, N, OR BLANK
069	INVALID OCCURRENCE DATE
071	STATEMENT COVERS FROM DATE INVALID
072	STATEMENT COVERS THRU DATE INVALID
073	STATEMENT COVERS FROM DATE LESS THAN SERVICE FROM DATE
074	STATEMENT COVERS THRU DATE IS GREATER THAN SERVICE THRU
081	INVALID OR MISSING PATIENT STATUS DATE
082	INVALID PATIENT STATUS CODE
085	INVALID OR MISSING UNITS VISITS AND STUDIES
093	REVENUE CODE MISSING/INVALID
095	CONDITION CODE 40 FROM THROUGH NOT EQUAL
096	REVENUE CHARGE MISSING OR INVALID
097	NON-COVERED CHARGES EXCEED BILLED CHARGES
098	BILL CLASS 2 REQUIRES MEDICARE ALLOWED AMOUNT IN LOC#54
101	INVALID EMERGENCY INDICATOR
114	INVALID OR MISSING HCPCS CODE
115	HCPCS CODE NOT ON FILE
120	QUANTITY INVALID/MISSING

EDIT CODE	EDIT DISPOSITION – DENY (REPAIRABLE OR REPAIRABLE UNDER LIMITED CIRCUMSTANCES)[1] EDIT DESCRIPTION
127	NDC INVALID/MISSING
131	PRIMARY DIAGNOSIS NOT ON FILE
180	THE ADMISSION DATE WAS NOT A VALID DATE
183	SURGICAL PROCEDURE NOT ON FILE
186	CERTIFIED REGISTERED NURSE ANESTHETISTS MUST BILL CORRECT MODIFIER
206	BILLING PROVIDER NOT ON FILE
211	DATE OF SERVICE LESS THAN DATE OF BIRTH
215	RECIPIENT NOT ON FILE
260	ANESTHESIA BASE UNITS ARE NOT ON FILE
269	ANESTHESIOLOGIST CPT NOT COVERED FOR MEDICAID ONLY-BILL SURG+MOD
273	3RD PARTY CARRIER CODE MISSING; REFER TO CARRIER CODE LIST
289	INVALID PROVIDER NUMBER WHEN DENY APPLIED
301	EMERGENCY ACCESS HOSPITAL - NATURE OF ADMISSION MUST BE EMERGENCY
307	SURGICAL PROCEDURE MISSING
309	DATE OF SURGERY MISSING
310	DATE OF SURGERY LESS THAN SERVICE FROM DATE
311	DATE OF SURGERY GREATER THAN SERVICE THRU DATE
376	ADJUSTMENT DAYS CONFLICT WITH HISTORY DAYS
430	MODIFIER NOT NEEDED-REMOVE AND RESUBMIT
444	MISSING/INVALID SERVICE PROVIDER
506	SUBMITTING PROVIDER IS NOT A CCN
513	HCPCS REQUIRED
539	CLAIM REQUIRES DETAILED BILLING
702	NEW PATIENT/ESTABLISHED PATIENT CODE CONFLICT
796	ORIG/ADJ BILLING PROVIDER NUMBER DIFFERENT
799	NO HISTORY RECORD ON FILE FOR THIS ADJUSTMENT
914	UNITS DO NOT MATCH DATES OF SERVICE/CLAIMCHECK
930	BILL ONE PROCEDURE PER LINE FOR EACH DATE OF SERVICE
931	DENIED PER THE TPL EOB INFORMATION
933	INVALID/MODIFIER/PROCEDURE CODE COMBINATION
946	SPLIT BILL FOR PARTIAL ELIGIBILITY.
949	ANESTHESIA MINUTES INVALID OR MISSING
980	INVALID ADJUSTMENT REASON
983	SYSTEM CALCULATED TOTAL - NET BILLED NOT IN BALANCE

4

Transaction Testing and EDI Certification

Introduction

The intake of encounter data from the PIHP is treated as HIPAA-compliant transactions by DHH and its FI. As such, the PIHP is required to undergo Trading Partner testing with the FI prior to electronic submission of encounter data. Testing is conducted to verify that the transmission is free of format errors. In order to simulate a production environment, the PIHP is requested to send real transmission data (NOTE: If the PIHP is testing prior to contract go-live, the PIHP may use mock encounter data in coordination with the Mediciad FI. Once the contract goes live, the PIHP will use real encounter data). The FI does not define the number of encounters in the transmission; however, DHH will require a minimum set of encounters for each transaction type based on testing needs.

If a PIHP rendering contracted provider has a valid NPI and taxonomy code, the PIHP will submit those values in the 837. If the provider is an atypical provider, the PIHP must follow 837 atypical provider guidelines.

Prior to testing, the PIHP must supply DHH with documentation of provider information publicly available through the Freedom of Information Act (FOIA) from the National Provider and Plan Enumeration System (NPPES). The NPI Registry enables you to search for a provider's NPPES information. All information produced by the NPI Registry is provided in accordance with the NPPES Data Dissemination Notice. In addition, DHH will provide the PIHP with a list of provider types and specialties. The PIHP is to provide the provider type and specialty in addition to the data elements available through NPPES.

Test Process

The Electronic Data Interchange (EDI) protocols are available at:

http://www.lmmis.com/provweb1/HIPAA/5010v_HIPAA_Index.htm

Electronic Data Interchange (EDI)

Enrollment as an EDI submitter is achieved through the completion of the DHH/FI approval process and the successful testing of provider encounters of a particular

claim type. The FI EDI Coordinator is available to assist in answering questions, but enrollment and participation proceed through the following steps:

- Upon request from the PIHP, the FI will provide application and approval forms for completion by the submitter. When completed, these forms must be submitted to the FI Provider Enrollment Unit.
- During the authorization process, the PIHP can call the EDI Department to receive EDI specifications that contain the data and format requirements for creating EDI claims. Using these specifications, the potential submitter develops and tests application software to create EDI encounters.
- Molina requires the PIHP to certify with a third-party vendor, EDIFECS, prior to submitting test claims to Molina.
- When the submitter is ready to submit a file of test encounters, the test encounters shall be submitted to the FI EDI Coordinator using the submitter number: 4509999. The test submission is run through Louisiana Medicaid Management Information System (MMIS) programs that validate the data and formats. Reports produced from this testing are reviewed by the FI. The test results are verified and the submitter is contacted to review any problems with the submission. If necessary, additional test encounters will be submitted until an acceptable test run is completed.

  NOTE: This test submitter number (4509999) shall be used for submission of test encounters only.

When all forms have been received and approved by the FI's Provider Enrollment Unit, and the EDI Department has verified the test claims, the submitter will be notified that EDI encounters may be submitted.

Once the PIHP becomes an approved EDI submitter, the billing process will be as follows:

- Upon receipt of the submission, the FI's EDI Department logs the submission and verifies it for completeness. If the submission is not complete, the log is rejected and the submitter is notified about the reject reason(s) via electronic message or telephone call.
- If the certification form is complete, the EDI Department enters the submitted encounters into a pre-processor production run. The pre-processor generates an encounter data file and one report. The Claims Transmittal Summary report, which lists whether a provider's batch of encounters has been accepted or rejected, is generated for each submission. If a provider's encounters are rejected, the provider number, dollar amount, and number of encounters are listed on the report.

The PIHP will submit to DHH and its FI a test plan with systematic plans for testing the ASC X12N 837 COB. The plan consists of three (3) tiers of testing, which are outlined in Appendix H.

Timing

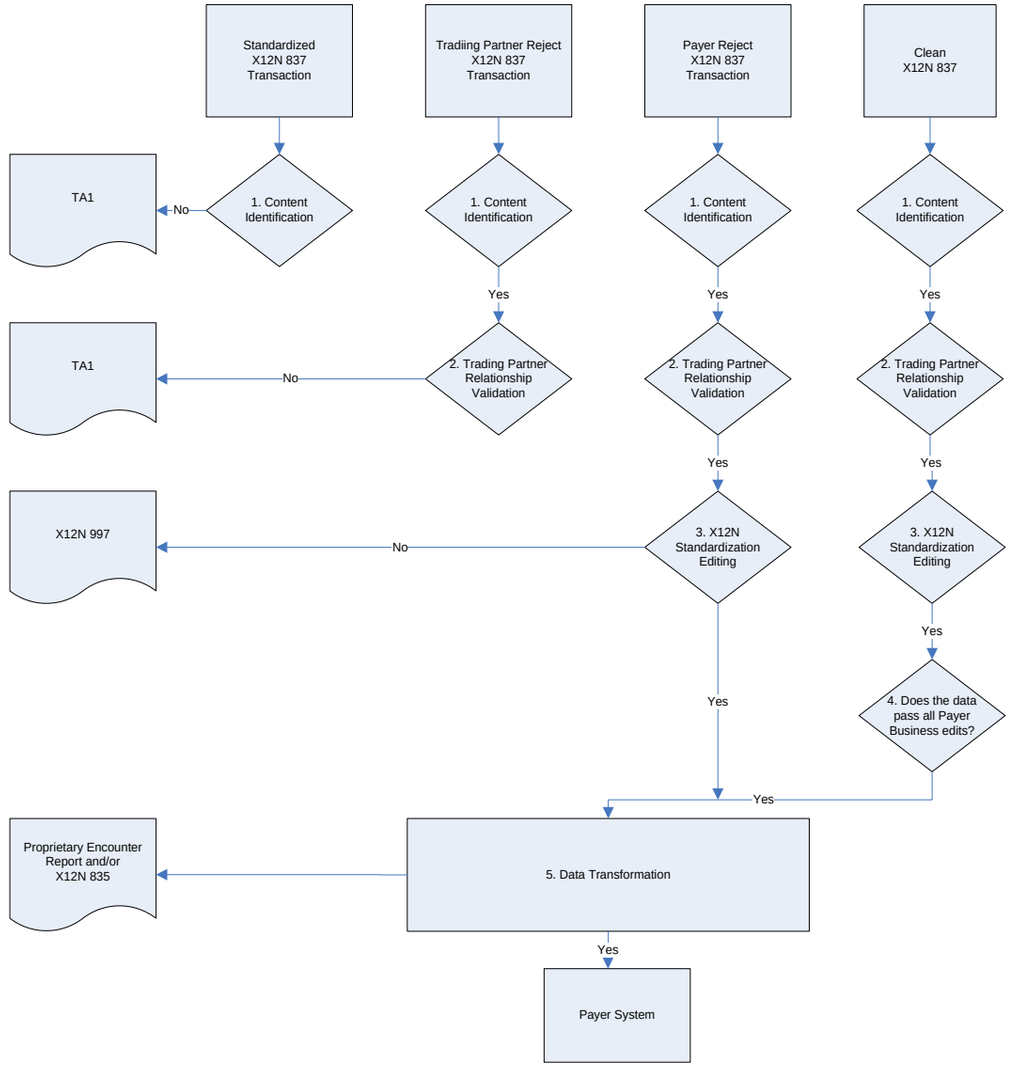
The PIHP may initiate EDIFECS testing at any time. DHH's FI Business Support Analysts are ready to answer technical questions and to arrange testing schedules and EDIFECS enrollment. Please refer to the FI Companion Guides for specific

instructions, located at: www.lamedicaid.com/provweb1/HIPAABilling/HIPAAindex.htm

Editing and Validation Flow Diagram

The following process flow chart depicts an incoming ANSI ASC X12N 837 transaction validation for syntax of the FI Electronic Data Interchange (EDI).

Molina Electronic Data Interchange (EDI):
Incoming ANSI ASC X12N 837
Transaction Validation for Syntax



Encounter Data Certification

The Federal Budget Balance Act (BBA) requires that when State payments to the PIHP are based on data that is submitted by the PIHP, the data must be certified. This certification applies to enrollment data, encounter data, and any other information that is specified by the State. The certification must attest, based on best knowledge, information, and belief, to the accuracy, completeness, and truthfulness of the data and any documents submitted as required by the State. Encounter files submitted by the PIHP, which are used to create payments and/or develop/support capitated rates, must be certified by a completed signed Data Certification form, which is required to be submitted concurrently with each encounter submission. The data must be certified by one of the following individuals:

- PIHP's Chief Executive Officer (CEO); or
- PIHP's Chief Financial Officer (CFO); or
- An individual who has the delegated authority to sign for, and who reports directly to the CEO or CFO.

DHH-LA DEPARTMENT OF HEALTH AND HOSPITALS ENCOUNTER DATA CERTIFICATION FORM

Please Type or Print Clearly	
Managed Care Organization	**Name of Preparer/Title**
For The Period Ending **_____, 20____**	**Contact Phone Number/Email Address**

BAYOU Health DATA Certification Statement

On behalf of the above-named PIHP, I attest, based on best knowledge, information and belief, that all data submitted to the DHH - LA Department of Health and Hospitals is accurate, complete, and true. This statement applies to all documents and files submitted to DHH.

I understand that any knowing and willful false statement or representation on this data submission form or attachment(s) may be subject to prosecution under applicable Federal and State laws. In addition, any knowing and willful failure to fully and accurately disclose the requested information may result in termination of the Bayou Health Plan contract.

File Type	ISA FILE #	Date File Sent (MMDDYR)	Total Number of Records	Sum Charged Amount	Sum of Paid Amount

Date Form Submitted:_____

Please circle as appropriate. Original Submission? Y N Void? Y N
Resubmission of Corrected or Voided Encounters ? Y N

Signature
This certification must be signed by the Chief Executive Officer or Chief Financial Officer, or an individual who has delegated authority to sign for, and who reports directly to the Chief Executive Officer or Chief Financial Officer. Please check here if a delegated authority is certifying this submission _____

_____	_____	_____
Date	PIHP Chief Executive Officer/Delegate Name & Title	Signature
_____	_____	_____
Date	PIHP Financial Officer/Delegate Name & Title	Signature

5

Data Management and Error Correction Process

Introduction

Encounter data is submitted through the FI's Electronic Data Interchange (EDI). Once received, 837 transactions are subject to initial edits. Further edits are applied during MMIS encounter processing.

Rejection Criteria

Incoming 837s may be rejected either at the FI's Electronic Data Interchange (EDI) or during the MMIS encounter processing. At the FI's Electronic Data Interchange (EDI), there are four levels (batch, syntax, claim header or service line) where edits (data validation processes) are present. Rejection of an entire batch or a single encounter is designated by the edit level in which the error occurs. Line level errors may also occur in the MMIS processing system. DHH will require The PIHP to correct certain MMIS line level errors.

Entire File

Rejection of an entire batch is designated by the edit level in which the error occurs. Interchange Level Errors will result in the rejection of an entire batch and the generation of a TA1 Rejection Report.

The TA1 is an ANSI ASC X12N Interchange Acknowledgement segment that is used to report receipt of individual envelopes. An interchange envelope contains the sender, receiver, and data type information for the header. If the syntactical analysis of the interchange header and trailer is invalid, the interchange will reject and a TA1 will be forwarded to the Molina Call Center. In this scenario, the entire transaction is rejected at the header level.

Once the transaction has passed interchange edits, it shall be subject to transaction set syntax errors. If the error occurs at the ST or SE level segments, the entire transaction is rejected. These edits are reported on the ANSI ASC X12N 997.

Claim

Transactions with errors at the ST or SE level segments are rejected in their entirety. However, if the functional group consists of additional transactions without

errors, these transactions are processed. The 999 transaction contains ACCEPT or REJECT information. If the file contains syntactical errors, the segment(s) or elements(s) where the error(s) occurred are reported.

Once the transaction has passed through syntactical edits, the transaction is edited according to implementation guide rule sets and payer-specific requirements. Any errors that occur at this level will result in the data content within that encounter being rejected. The ANSI ASC X12N 824 may be used to report those errors.

Service Line

Data that passes the FI's edits will proceed to the data transformation step for processing. In this step, certain data elements are converted into a format that is acceptable for claims processing. During processing, the MMIS will apply specific edits to the encounters. Depending upon the level of edit, an individual encounter may deny at the header or at a single detailed line.

A listing of encounter edits is contained in Appendix F. After processing, an 835 Remittance Advice is returned to the sender.[2]

Encounter Correction Process

The PIHP is required to correct and resubmit any transactions or encounters that are rejected or denied and are Repairable. For service line rejections, the PIHP is required to correct and resubmit errors that are known to be "repairable". A list of repairable denials is contained in Section 3 of this Guide.

Reports

On a weekly basis, the FI will provide the following weekly edit code reports to the PIHP:

- SMO-W-005-–Summarization of Edit Codes for Encounters Processing
- SMO-W-010 – Weekly list of all Encounters and their Error Codes for Encounter processing

The reports are available to the PIHP one (1) day after production by the MMIS adjudication cycle. The PIHP may access the reports via the lamedicaid.com website.

Upon reviewing the above weekly reports, the PIHP is required to make the necessary correction(s) to encounter(s) in which a Repairable Edit is applied,

[2] If requested by the PIHP and prearranged with DHH

and in accordance with an approved Quality Improvement Plan. The PIHP is required to resubmit the corrected encounter to the FI for processing.

Electronic Notifications

The PIHP may receive one or more of the following electronic notifications from the FI for any HIPAA EDI file rejection(s) or encounter denial(s):

- EDIFECS File Processing Error In Production Environment
- EMC Translation Error in Production File
- Translation Failure
- Back End Rejections

The PIHP is required to make correction(s) to all service line(s) to which a repairable edit code was applied.

If an encounter is denied in its entirety, the PIHP is required to correct all lines of the encounter to which Repairable Edit code(s) is/are applied. The corrected encounter must be resubmitted to the FI for re-processing.

Entire File

The PIHP will receive either a TA1 or X12N 999 error report. The PIHP is required to work with the FI's Business Support Analysts to determine the cause of the error.

Claim

The PIHP will receive either an X12 835 or proprietary reports for header level rejections. The PIHP is responsible for adherence to the implementation guide, code sets, and looping structures for the transaction. The PIHP will also be responsible for adhering to the DHH payer-specific data rules, as defined in the FI's Companion Guide and Section 2 of this Guide.

Service Line

The PIHP will receive an X12N 835 for transaction claims that have processed through the MMIS. If the service line fails MMIS encounter edits, an adjustment reason code, adjustment amount, and adjustment quantity are returned in the CAS segment of loop 2110.

This CAS segment is optional and is intended to reflect reductions in payment due to adjustments particular to a specific service in the encounter. An example of this level of CAS is the reduction for the part of the service charge that exceeds the usual and customary charge for the service. See 2.2.1, Balancing, and 2.2.4, Claim Adjustment and Service Adjustment Segment Theory in the 835 IG, for additional information.

A single CAS segment contains six repetitions of the “adjustment trio” composed of adjustment reason code, adjustment amount, and adjustment quantity. These six adjustment trios are used to report up to six adjustments related to a particular Claim Adjustment Group Code (CAS01). The first adjustment is reported in the first adjustment trio (CAS02-CAS04). If there is a second non-zero adjustment, it is reported in the second adjustment trio (CAS05-CAS07), and so on through the sixth adjustment trio (CAS17-CAS19).

Each adjustment reason is associated with a particular MMIS edit code. The PIHP is presented with an edit code report to assist them in identifying repairable errors. The PIHP is responsible for correcting and resubmitting service line denials.

Outstanding Issues

After implementing the data management and error correction process and any processing error(s) remaining unresolved, the PIHP may present the outstanding issue(s) to DHH-OBH and DHH’s FI for clarification or resolution. DHH-OBH and its FI will review the issue(s) and triage the issue(s) to the appropriate entity for resolution and respond to the PIHP with their findings. If the outcome is not agreeable to the PIHP, the PIHP can re-submit the outstanding issue(s) with supporting documentation to DHH for reconsideration. The outcome determined by DHH will prevail.

Dispute Resolution

The PIHP has the right to file a dispute regarding rejected encounters. Disputes must be filed within thirty (30) days of identifying an issue for dispute. The PIHP may believe that a rejected encounter is the result of a "FI error". A FI error is defined as a rejected encounter that (1) the FI acknowledges to be the result of its own error, and (2) requires a change to the system programming, an update to MMIS reference tables, or further research by the FI, and therefore requires FI resolution to process the rejection.

The PIHP must notify DHH-OBH in writing within thirty (30) calendar days if it believes that the resolution of a rejected encounter rests on the FI rather than the PIHP. The FI, on behalf of DHH, will respond in writing within thirty (30) days of receipt of such notification. DHH encourages the PIHP to provide written notice as soon as possible. The FI response will identify the status of each rejected encounter problem or issue in question.

For ease in filing written requests, the PIHP may use the Edit Reports provided by the FI. The PIHP shall highlight, or otherwise note, the rejected encounters to be researched, and attach a memorandum describing the problem.

6

Adjustment Process and Void Process

Introduction

In the case of adjustments and voids, the PIHP is to follow the detailed, payer-specific instructions provided in the FI's Companion Guides found at:

www.lamedicaid.com/provweb1/HIPAABilling/HIPAAindex.htm.

To adjust an encounter or claim with a line level denial, make the correction(s) to the encounter or claim and resubmit via 837 transaction file using the instructions below.

Line Adjustment Process

Loop	*Segment*	*Data Element*	*Comments*
2300	CLM05-3	1325	Claim Frequency Type Code To adjust a previously accepted record, submit a value of "**7**". See also 2300/REF02. To void a previously submitted claim, submit a value of "**8**". See also 2300/REF02
2300	REF01	128	Reference Identification Qualifier To adjust or void a previously accepted record, submit "**F8**" to identify the Original Reference Number.
2300	REF02	127	Original Reference Number To adjust a previously accepted record, please submit the **13-digit ICN** assigned by the adjudication system and printed on the remittance advice, for the previously accepted record that is being adjusted or voided by this claim.

For claim level denials, make the correction(s) and resubmit.

Molina ICN Format

The format of the Molina ICN is as follows:

- Digit 1 = Last digit of year of receipt
- Digits 2-4 = Julian day* of the year of receipt

- Digit 5 = Media Code with value of 1(EDI)
- Digits 6-8 = 3 digit batch number
- Digits 9-11 = 3 digit sequential number in batch
- Digit 12-13 = claim line number

** Julian day - A calendar notation in which the date is represented by one number. For example, the Julian date for December 11, 1942 is 2430705; while December 12, 1942 is 2430706.*

7

Managed Care Behavioral Health Crossover Claims

The Medicaid FI will process all crossover claims. Claims payment for Dual Eligible covered services including CSoC Waiver Services, Community Psychiatric Support and Treatment (including the evidence-based practices), Psychosocial Rehabilitation, Crisis Intervention, and Substance Use Treatments is the responsibility of the PIHP. These services are considered Medicaid-unique, as the services are not covered by Medicare.

The services include the following HCPCS:

S5110, H0038, H2014, S5150, H0045, H2017, S9485, H2011, H0036, H0039, H2033, H0001, H0004, H0005, H0011, H0012, H0015, H0019, H2034, H2036, H0049, and H0050.

8

Medicare Recovery Process

On a monthly basis, the Fiscal Intermediary will run a Medicare Recovery Process. This process identifies recipients who are retrospectively enrolled in Pure Medicare (i.e., QMB, SLMB, QDWI, QI-1, or QI-2.), but do not also qualify for full Medicaid including PMPM payments and generates voids to recover payments.

The process takes the Fiscal Intermediary two weeks – the first week to identify the recipients who are retrospectively enrolled, and the second week to process the voids.

The Fiscal Intermediary will generate an 820 file with the detail information regarding the voids for any past PMPM payments made to the Plan. The process runs monthly on the following schedule:

- Last week of January and first week of February
- Last week of April and first week of May
- Last week of July and first week of August
- Last week of October and first week of November

The 820 File Layout can be found in **Appendix D** of this Guide.

9

Department of Correction (DOC) PMPM Recoveries

On a monthly basis, the Fiscal Intermediary will run a Recovery Process for members whose incarceration period encompassed the entire month. Members are identified via lock-in code 5 or 6.

The Fiscal Intermediary will generate an 820 file with the detail information regarding the voids for any past PMPM payments made to the Plan. The process runs monthly on the following schedule:

- Last week of January and first week of February
- Last week of April and first week of May
- Last week of July and first week of August
- Last week of October and first week of November

The 820 File Layout can be found in **Appendix D** of this Guide.

10

Date of Death (DOD) PMPM Recoveries

On a monthly basis, the Fiscal Intermediary will run a Recovery Process for deceased members based on date of death. The Recovery Process identifies deceased members for whom Medicaid has continued to pay a PMPM subsequent to the month of death.

The Fiscal Intermediary will generate an 820 file with the detail information regarding the voids for any past PMPM payments made to the Plan. The process runs monthly on the following schedule:

- Last week of January and first week of February
- Last week of April and first week of May
- Last week of July and first week of August
- Last week of October and first week of November

The 820 layout can be found in Appendix D of this guide.

11

Medicaid Administrative Retroactive Enrollment Correction Process

DHH has determined that in some instances, Administrative Retroactive Corrections to member linkages are necessary to ensure compliance with internal policies and the approved Medicaid state plan. These corrections, also known as retro, may address multiple months, and significantly impact paid claims and PMPMs. In an effort to correct audit trails.

The FI's monthly process for establishing PMPMs for retrospectively enrolled recipients is:

a. Identify eligible recipients who have retro enrollments in the month prior to the current month and have no PMPM.

b. Identify children who have retro enrollments in the month prior to the current month and have no PMPM.

A monthly report of affected members is given to SMOPIHP. This report includes detailed information to assist the SMOPIHP in anticipating claims which should be billed to them for their retro enrolled members including:

- Member name, Medicaid ID and voided claim detail;
- If applicable, original authorization (PA and Pre-cert) numbers;
- Identification of the entity that paid the original claim; and
- Identification of the correct entity responsible for prior paid claims due to the retro enrollment

Appendix A

Definition of Terms

The following terms shall be construed and interpreted as follows unless the context clearly requires otherwise.

837 Format	The file format used for electronic billing of professional services, institutional services or dental services. ANSI 837 is shorthand for the ASC X12N 837 (004010X098A1) file format.
999 Functional Acknowledgment	Transaction set-specific verification is accomplished using a999 Functional Acknowledgement. The transaction set can be used to define the control structures for a set of acknowledgments to indicate the results of the syntactical analysis of the electronically encoded documents.
Agent	Any person or entity with delegated authority to obligate or act on behalf of another party.
Atypical providers	Individuals or businesses that bill Medicaid for services rendered, and may not meet the definition of a health care provider according to the NPI Final Rule 45 CFR 160.103 (e.g., carpenters, transportation providers, etc).
CAS Segment	Used to report claims or line level adjustments.
Centers for Medicare and Medicaid Services (CMS)	The agency within the U.S. Department of Health & Human Services that provides administration and funding for Medicare under Title XVIII, Medicaid under Title XIX, and the Children's Health Insurance Program under Title XXI of the Social Security Act. This agency was formerly known as the Health Care Financing Administration (HCFA).
Claim	A request for payment for benefits received or services rendered.

Claim adjustment	A reason why a claim or service line was paid differently than it was billed. Adjustments are communicated by adjustment reason codes.
Claim denial	When a claim does not meet the criteria of being complete or does not meet all of the criteria for payment under health plan rules.
Claims adjudication	In health insurance claims, adjudication refers to the determination of the insurer's payment or financial responsibility, after the member's insurance benefits are applied to a medical claim.
Clean claim	A claim that has no defect or impropriety (including any lack of required substantiating documentation) or particular circumstance requiring special treatment that prevents timely payment of the claim. It does not include a claim from a provider who is under investigation for fraud or use or a claim under review for medical necessity.
Core Benefits and Services	A schedule of health care benefits and services required to be provided by the PIHP to Medicaid CSoC members as specified under the terms and conditions of the Contract and Louisiana Medicaid State Plan and waivers as outlined in the contract's service definition manual.
CMS 1500	A universal claim form, required by CMS, to be used by non-institutional and institutional providers that do not use the UB-92.
CommunityCARE 2.0	Refers to the Louisiana Medicaid Primary Care Case Management (PCCM) program, which links Medicaid enrollees to a primary care provider as their medical home.
BAYOU HEALTH Network	An entity designed to improve performance and health outcomes through the creation of cost effective integrated healthcare delivery system that provides a continuum of evidence-based, quality-driven healthcare services for Medicaid eligibles.
Coordination of Benefits (COB)	Refers to the activities involved in determining Medicaid benefits when a recipient has coverage through an individual, entity, insurance, or program that is liable to pay for health care services.
CSoC	Coordinated System of Care

CSoC eligible	Children and youth eligible for the CSoC
Co-payment	Any cost sharing payment for which the Medicaid PIHP member is responsible for in accordance with 42 CFR § 447.50 and Section 5006 of the American Recovery and Reinvestment Act (ARRA) for Native American members.
Corrective Action Plan (CAP)	A plan developed by the PIHP that is designed to ameliorate an identified deficiency and prevent reoccurrence of that deficiency. The CAP outlines all steps/actions and timeframes necessary to address and resolve the deficiency.
Corrupt data	Data corruption refers to errors in electronic data that occur during transmission, retrieval, or processing, introducing unintended changes to the original data. Computer storage and transmission systems use a number of measures to provide data integrity and the lack of errors. In general, when there is a Data Corruption, the file containing that data would be inaccessible, and the system or the related application will give an error. There are various causes of corruption.
Data Certification	The Balanced Budget Act (BBA) requires that when State payments to a (PIHP) are based on data that is submitted by the BH the data must be certified. This certification applies to enrollment data, encounter data, and any other information that is specified by the State. The certification must attest, based on best knowledge, information, and belief, to the accuracy, completeness, and truthfulness of the data and any documents submitted as required by the State.
Denied claim	A claim for which no payment is made to the network provider by the PIHP for any of several reasons, including but not limited to, the claim is for non-covered services, the provider or Member is ineligible, the claim is a duplicate of another transaction, or the claim has failed to pass a significant requirement (or edit) in the claims processing system.
Department (DHH)	The Louisiana Department of Health and Hospitals, referred to as DHH.
Department of Health and Human Services (DHHS; also HHS)	The United States government's principal agency for protecting the health of all Americans and providing essential human

	services, especially for those who are least able to help themselves. The DHHS includes more than 300 programs, covering a wide spectrum of activities, including medical and social science research; preventing outbreak of infectious disease; assuring food and drug safety; overseeing Medicare, Medicaid and CHIP; and providing financial assistance for low-income families.
Dispute	An expression of dissatisfaction about any matter other than an action, as action is defined. Examples of a Dispute include dissatisfaction with quality of care, quality of service, rudeness of a provider or a network employee, and network administration practices. Administrative Disputes are generally those relating to dissatisfaction with the delivery of administrative services, coverage issues, or access to care issues.
Duplicate claim	A claim that is either a total or a partial duplicate of services previously paid.
Early and Periodic Screening, Diagnosis and Treatment (EPSDT)	A federally required Medicaid benefit for individuals under the age of 21 years that expands coverage for children and adolescents beyond adult limits to ensure availability of 1) screening and diagnostic services to determine physical or mental defects and 2) health care, treatment, and other measures to correct or ameliorate any defects and chronic conditions discovered (CFR 440.40 (b)). EPSDT requirements help to ensure access to all medically necessary health services within the federal State Plan definition of "medical assistance". Note: 1915(c) waiver services for children are not covered under EPSDT.
Edit Code Report	A proprietary report prepared by the Fiscal Intermediary that includes all of the edit codes for each claim line and each claim header. Some edit codes indicate that the encounter has denied. Other edit codes are informational only.
EDI Certification	EDI Certification essentially provides a snapshot that asserts an entity is capable at that point in time of generating or receiving compliant files. It is based solely on the files that have been tested and submitted for certification. Specifically, it is based on the exact capabilities that are reflected within those

	files. Testing and certification are typically done through a third party vendor prior to encounters being submitted to the Fiscal Intermediary.
Eligible	An individual qualified to receive services through the PIHP
Emergency Medical Condition	A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: (1) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, (2) serious impairment to bodily functions, or (3) serious dysfunction of any bodily organ or part. Emergency care requires immediate face-to-face medical attention.
Encounter data	Records of medically-related services rendered by a provider to the PIHP Member on a specified date of service. This data is inclusive of all services for which the PIHP has any financial liability to a provider PIHP
Enrollee	A Louisiana Medicaid or CHIP eligible (recipient) who is currently enrolled in the CSoC.
Evidence-Based Practice	Clinical interventions that have demonstrated positive outcomes in several research studies to assist individuals in achieving their desired goals of health and wellness.
External Quality Review Organization (EQRO)	An organization that meets the competence and independence requirements set forth in 42 CFR 438.354, and performs EQR, and other related activities as set forth in federal regulations, or both.
Federally Qualified Health Center (FQHC)	An entity that receives a grant under Section 330 of the Public Health Service Act, as amended, (also see Section 1905(1) (2) (B) of the Social Security Act), to provide primary health care and related diagnostic services and may provide dental, optometric, podiatry, chiropractic and behavioral health services.
Fee for Service (FFS)	A method of provider reimbursement based on payments for specific services rendered to an enrollee.

File Transfer Protocol (FTP)	Software protocol for transferring data files from one computer to another with added encryption.
Fiscal Intermediary (FI) for Medicaid	DHH's designee or agent responsible in the current delivery model for an array of support services including MMIS development and support, claims processing, pharmacy support services, provider support services, financial and accounting systems, prior authorization and utilization management, fraud and abuse systems, and decision support.
Fiscal Year (FY)	Refers to budget year – A Federal Fiscal Year is October 1 through September 30 (FFY); A State Fiscal Year is July 1 through June 30 (SFY).
Fraud	As it relates to the Medicaid Program Integrity, means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to him or some other person. It includes any act that constitutes fraud under applicable Federal or State law. Fraud may include deliberate misrepresentation of need or eligibility; providing false information concerning costs or conditions to obtain reimbursement or certification; or claiming payment for services which were never delivered or received.
Health Care Professional	A physician or other health care practitioner licensed, accredited, or certified to perform specified health services consistent with State law.
Health Care Provider	A health care professional or entity that provides health care services or goods.
HIPAA – Health Insurance Portability Administration Act	The Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA, Title II) required the Department of Health and Human Services (HHS) to establish national standards for electronic health care transactions and national identifiers for providers, health plans, and employers. As the industry has implemented these standards, and increased the use of electronic data interchange, the nation's health care system will become increasingly effective and efficient.

Immediate	In an immediate manner; instant; instantly or without delay, but not more than 24 hours.
Information Systems (IS)	A combination of computing hardware and software that is used in: (a) the capture, storage, manipulation, movement, control, display, interchange and/or transmission of information, *i.e*. structured data (which may include digitized audio and video) and documents; and/or (b) the processing of such information for the purposes of enabling and/or facilitating a business process or related transaction.
Interchange Envelope	Trading partners shall follow the Interchange Control Structure (ICS), Functional Group Structure (GS), Interchange Acknowledgment (TA1), and Functional Acknowledgement (997) guidelines for HIPAA that are located in the HIPAA Implementation Guides in Appendix A and B.
Internal Control Number (ICN)	DHH's FI assigns each claim an Internal Control Number (ICN) systematically when it is received electronically or by mail. Processing or returning the claim constitutes the FI's final action on that claim. A resubmission of the same claim is considered a new claim. Each claim sent to the FI is assigned an ICN automatically, which is used to track the claim. The ICN is made up of 13 digits following a specific format. The format of the ICN enables you to determine when the FI actually received the claim.
	PIHP PIHP
Louisiana Department of Health and Hospitals (DHH)	The state department responsible for promoting and protecting health and ensuring access to medical, preventive and rehabilitative services for all citizens in the state of Louisiana.
Medicaid	A means tested federal-state entitlement program enacted in 1965 by Title XIX of the Social Security Act. Medicaid offers federal matching funds to states for costs incurred in paying health care providers for serving eligible individuals.
Medicaid FFS Provider	An institution, facility, agency, person, corporation, partnership, or association that has signed a PE 50 agreement, has been

	approved by DHH, and accepts payment in full for providing benefits, the amounts paid pursuant to approved Medicaid reimbursement provisions, regulations and schedules.
Medicaid Management Information System (LMMIS)	A mechanized claims processing and information retrieval system, which all states Medicaid programs are required to have, and which must be approved by the Secretary of DHHS. This system is an organized method of payment for claims for all Medicaid services and includes information on all Medicaid Providers and Eligibles.
Medicaid Recipient	An individual who has been determined eligible, pursuant to federal and state law, to receive medical care, goods or services for which DHH may make payments under the Medicaid or CHIP Program, who may or may not be currently enrolled in the Medicaid or CHIP Program, and on whose behalf payment is made.
Medical Vendor Administration (MVA)	The name for the budget unit specified in the Louisiana state budget that contains the Bureau of Health Services Financing (Louisiana's single state Medicaid Agency).
Medically Necessary Services	Health care services that are in accordance with generally accepted, evidence-based medical standards, or that are considered by most physicians (or other independent licensed practitioners) within the community of their respective professional organizations to be the standard of care. In order to be considered medically necessary, services must be: 1) deemed reasonably necessary to diagnose, correct, cure, alleviate or prevent the worsening of a condition or conditions that endanger life, cause suffering or pain or have resulted or will result in a handicap, physical deformity or malfunction; and 2) not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease. Any such services must be clinically appropriate, individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and neither more nor less than what the patient requires at that specific point in time. Services that are experimental, non-FDA approved, investigational, cosmetic,

	or intended primarily for the convenience of the recipient or the provider, are specifically excluded from Medicaid coverage and will be deemed "not medically necessary". The Medicaid Director, in consultation with the Medicaid Medical Director, may consider authorizing such a service in his discretion on a case-by-case basis.
Medicare	The federal medical assistance program in the United States authorized in 1965 by Title XVIII of the Social Security Act, to address the medical needs of older American citizens. Medicare is available to U.S. citizens 65 years of age and older and some people with disabilities under age 65.
Member	Persons enrolled in the CSoC .
National Provider Identifier (NPI)	The National Provider Identifier (NPI) is a Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification Standard. The NPI is a unique identification number for covered health care providers. Covered health care providers and all health plans and health care clearinghouses must use the NPIs in the administrative and financial transactions adopted under HIPAA. The NPI is a 10-position, intelligence-free numeric identifier (10-digit number). This means that the numbers do not carry other information about healthcare providers, such as the state in which they live or their medical specialty. The NPI must be used in lieu of legacy provider identifiers in the HIPAA standards transactions.
Network	As used in the Contract, "network" may be defined as a group of participating providers linked through contractual arrangements to a PIHP to supply a range of behavioral health care services. The term "provider network" may also be used.
Non-Contracting Provider	A person or entity that provides hospital or medical care, but does not have a contract, or agreement with the PIHP.
Non-Covered Services	Services not covered under the Title XIX Louisiana State Medicaid Plan.
Non-Emergency	An encounter by a PIHP member who has presentation of medical signs and symptoms, to a health care provider, and not requiring immediate medical attention.

Performance Measures	Specific operationally defined performance indicators utilizing data to track performance and quality of care and to identify opportunities for improvement related important dimensions of care and service.
Policies	The general principles by which DHH is guided in its management of the Title XIX program, and as further defined by DHH promulgations and by state and/or federal rules and regulations.
Primary Care Provider (PCP)	An individual physician or other licensed nurse practitioner responsible for the management of a member's health care who is licensed and certified in one of the following general specialties; family practitioner, general practitioner, general pediatrician, general internal medicine, general internal medicine and pediatrics, or obstetrician/ gynecologist. The primary care provider is the patient's point of access for preventive care or an illness and may treat the patient directly, refer the patient to a specialist (secondary/tertiary care), or admit the patient to a hospital.
Primary Care Services	Health care services and laboratory services customarily furnished by or through a primary care provider for diagnosis and treatment of acute and chronic illnesses, disease prevention and screening, health maintenance, and health promotion either through, direct service to the member when possible, or through appropriate referral to specialists and/or ancillary providers.
Prior Authorization	The process of determining medical necessity for specific services before they are rendered.
Prospective Review	Utilization review conducted prior to an admission or a course of treatment.
Protected Health Information (PHI)	Individually identifiable health information that is maintained or transmitted in any form or medium and for which conditions for disclosure are defined in the Health Insurance Portability and Accountability Act of 1996 (HIPAA) 45 CFR Part 160 and 164.
Provider	Either (1) for the Fee-For-Service Program, any individual or entity furnishing Medicaid services under an agreement with the Medicaid agency; or (2) for the PIHP Program, any individual or entity that is engaged in the

	delivery of health care services and is legally authorized to do so by the State in which it delivers services.
Provider Specialty	A second-level qualification code, specific to Louisiana Medicaid, that designates the specialty classification of a provider according to Louisiana State Plan for Medicaid (for example, for physicians, some specialties are General Practice, Pediatrics, Family Medicine, etc.).
Provider Type	A high-level identification code, specific to Louisiana Medicaid, that designates the service classification of a provider according to Louisiana State Plan for Medicaid (for example, physician, dentist, pharmacy, hospital, etc.).
Quality	As it pertains to external quality, review means the degree to which a PIHP increases the likelihood of desired health outcomes of its enrollees through its structural and operational characteristics and through the provision of health services that are consistent with current professional knowledge.
Quality Management (QM)	The ongoing process of assuring that the delivery of covered services is appropriate, timely, accessible, available and medically necessary and in keeping with established guidelines and standards and reflective of the current state of medical and behavioral health knowledge.
Readiness Review	Refers to the process where DHH assesses the PIHP 's ability to fulfill the requirements of the provider agreement. Such review may include, but is not limited to, review of proper licensure, operational protocols, PIHP standards, and systems. The review may be completed as a desk review, on-site review, or combination, and may include interviews with pertinent personnel so that DHH can make an informed assessment of the PIHP's ability and readiness to render services.
Recipient	An individual entitled to benefits under Title XIX of the Social Security Act, and under the Louisiana Medicaid State Plan who is or was enrolled in Medicaid and on whose behalf a payment has been made for medical services rendered.

Reject	Syntax validation will determine as to whether the data is a valid ANSI ASC X12N. A 997 (Functional Acknowledgement**)** will be returned to the submitter. The 997 contains **ACCEPT** or **REJECT** information. If the file contains syntactical errors, the segment(s) or element(s) where the error(s) occurred will be reported.
Remittance Advice	An electronic listing of transactions for which payment is calculated. Hard copies are available upon request only. Transactions may include but are not limited to, members enrolled in the PIHP,, payments for maternity, and adjustments.
Repairable Edit Code	An encounter that denies for a reason that is repairable (shall be fixed and resubmitted) will have an accompanying “repairable edit code “code” to indicate that the encounter is repairable.
Representative	Any person who has been delegated the authority to obligate or act on behalf of another. Also known as the authorized representative.
Risk	The chance or possibility of loss. Risk is also defined in insurance terms as the possibility of loss associated with a given population.
Rural Health Clinic (RHC)	A clinic located in an area that has a healthcare provider shortage that provides primary health care and related diagnostic services and may provide optometric, podiatry, chiropractic and behavioral health services; and which must be reimbursed on a prospective payment system.
SE Segment	The 837 transaction set trailer.
Security Rule (45 CFR Parts 160 & 164)	Part of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) which stipulates that covered entities must maintain reasonable and appropriate administrative, physical, and technical safeguards to protect the confidentiality, integrity, and availability of their Electronic Protected Health Information against any reasonably anticipated risks.
Service Line	A single claim line as opposed to the entire claim or the claim header.
Shall	Denotes a mandatory requirement.

Should, May, Can	Denotes a preference but not a mandatory requirement.
Social Security Act	The current version of the Social Security Act of 1935 (42 U.S.C.A. § 301 et seq.) as amended which encompasses the Medicaid Program (Title XIX) and CHIP Program (Title XXI).
Span of Control	Information systems and telecommunications capabilities that the PIHP itself operates, or for which it is otherwise legally responsible according to the terms and conditions of the Contract with DHH-OBH. The span of control also includes systems and telecommunications capabilities outsourced by the PIHP
ST Transaction Set Header	Indicates the start of a transaction set and to assign a control number.
State	The state of Louisiana.
Stratification	The process of partitioning data into distinct or non-overlapping groups.
Surveillance and Utilization Review Subsystems (SURS) Reporting	Surveillance and Utilization Review Subsystems is reporting as required in the subsection under Fraud, Abuse and Waste Prevention.
Syntactical Error	Syntax is the term associated with the "enveloping" of EDI messages into interchanges. Items included in Syntax Set maintenance include: "Delimiters" which separate individual elements and segments within the interchange; "Envelope segments" which denote the beginning and ending of messages, functional groups, and interchanges; and "Permitted Characters" which define the values allowed for a particular syntax set. Syntax validation will determine as to whether the data is a valid ANSI ASC X12N. A 997 (Functional Acknowledgement**)** will be returned to the submitter. The 997 contains **ACCEPT** or **REJECT** information. If the file contains syntactical errors, the segment(s) or element(s) where the error(s) occurred will be reported.
System Function Response Time	Based on the specific sub function being performed:

	• *Record Search Time*-the time elapsed after the search command is entered until the list of matching records begins to appear on the monitor. • *Record Retrieval Time*-the time elapsed after the retrieve command is entered until the record data begin to appear on the monitor. • *Print Initiation Time*- the elapsed time from the command to print a screen or report until it appears in the appropriate queue. • *On-line Claims Adjudication Response Time*- the elapsed time from the receipt of the transaction by the PIHP from the provider and/or switch vendor until the PIHP hands-off a response to the provider and/or switch vendor.
System Availability	Measured within the PIHP's information system span of control. A system is considered not available when a system user does not get the complete, correct full-screen response to an input command within three (3) minutes after depressing the "enter" or other function key.
TA1	The Interchange or TA1 Acknowledgment is a means of replying to an interchange or transmission that has been sent. The TA1 verifies the envelopes only. Transaction set-specific verification is accomplished through use of the Functional Acknowledgment Transaction Set, 997. The TA1 is a single segment and is unique in the sense that this single segment is transmitted without the GS/GE envelope structures. A TA1 can be included in an interchange with other functional groups and transactions. Trading partners shall follow the Interchange Control Structure (ICS), Functional Group Structure (GS), Interchange Acknowledgment (TA1), and Functional Acknowledgement (997) guidelines for HIPAA that are located in the HIPAA Implementation Guides in Appendix A and B.
Taxonomy codes	These are national specialty codes used by providers to indicate their specialty at the claim level. The taxonomy codes and code descriptions

	that health care providers select when applying for NPIs may or may not be the same as the categorizations used by Medicare and other health plans in their enrollment and credentialing activities. The taxonomy code or code description information collected by NPPES is used to help uniquely identify health care providers in order to assign them NPIs, not to ensure that they are credentialed or qualified to render health care.
Trading Partners	Covered entities who are involved in Electronic Data Interchange involving HIPAA ANSI transactions.
Utilization Management (UM)	Refers to the process to evaluate the medical necessity, appropriateness, and efficiency of the use of health care services, procedures, and facilities. UM is inclusive of utilization review and service authorization.
Validation	The review of information, data, and procedures to determine the extent to which data is accurate, reliable, free from bias and in accord with standards for data collection and analysis.
Will	Denotes a mandatory requirement.

Appendix B

Code Sets

The use of standard code sets will improve the effectiveness and efficiency of Medicaid, Federal, and other private health programs through system administration simplification and efficient electronic transmission of certain health information. *Code set* means any set of codes used to encode data elements, such as tables of terms, medical concepts, medical diagnostic codes, or medical procedure codes. A code set includes the codes and the descriptors of the codes.

When conducting 837 transactions, DHH requires the PIHP to adhere to HIPAA standards governing Medical data code sets. Specifically, the PIHP must use the applicable medical data code sets described in §162.1002, as specified in the IGs that are valid at the time the health care is furnished. The PIHP is also required to use the non-medical data code sets, as described in the IGs that are valid at the time the transaction is initiated.

DHH requires the PIHP to adopt the following standards for Medical code sets and/or their successor code sets:

International Classification of Diseases, 9th Edition, Clinical Modification (ICD-9-CM), Volumes 1 and 2 (including The Official ICD-9-CM Guidelines for Coding and Reporting), as maintained and distributed by DHHS, for the following conditions:

- Diseases;
- Injuries;
- Impairments;
- Other health problems and their manifestations; and
- Causes of injury, disease, impairment, or other health problems.

ICD-9-CM, Volume 3 Procedures (including The Official ICD-9-CM Guidelines for Coding and Reporting), as maintained and distributed by DHHS, for the following procedures or other actions taken for diseases, injuries, and impairments on inpatients reported by hospitals (ICD-10 will be implemented October 1, 2015):

- Prevention;
- Diagnosis;
- Treatment; and
- Management.

National Drug Codes (NDC), as maintained and distributed by DHHS, in collaboration with drug manufacturers, for the following:

- Drugs; and
- Biologics.

Current Dental Terminology (CDT) Code on Dental Procedures and Nomenclature, as maintained and distributed by the American Dental Association (ADA) for dental services.

The combination of Health Care Financing Administration Common Procedure Coding System (HCPCS), as maintained and distributed by HHS, and Current Procedural Terminology, Fourth Edition (CPT-4), as maintained and distributed by the American Medical Association (AMA), for physician services and other health care services. Category I CPT codes describe a procedure or service identified with a five-digit CPT code and descriptor nomenclature. The inclusion of a descriptor and its associated specific five-digit identifying G-code number in this category of CPT codes is generally based upon the procedure being consistent with contemporary medical practice and being performed by many physicians in clinical practice in multiple locations. Services described by Category I CPT codes include, but are not limited to, the following:

- The services manual outlined in the PIHP contract,
- Physician services,
- Physical and occupational therapy services,
- Radiological procedures,
- Clinical laboratory tests,
- Other medical diagnostic procedures

In addition to the Category I codes described above, DHH requires that the PIHP submit CPT Category II codes. CPT Category II codes are supplemental tracking G-codes that can be used for performance measurement. The use of the tracking G-codes for performance measurement will decrease the need for record abstraction and chart review, and thereby minimize administrative burdens on physicians and other health care professionals. These codes are intended to facilitate data collection about quality of care by coding certain services and/or test results that support performance measures and that have been agreed upon as contributing to good patient care. Some codes in this category may relate to compliance by the health care professional with state or federal law.

The HCPCS, as maintained and distributed by DHHS, for all other substances, equipment, supplies, or other items used in health care services. These items include, but are not limited to, the following:

- Medical supplies,
- Orthotic and prosthetic devices, and
- Durable medical equipment.
- Other services, as applicable, in the manual outlined in the PIHP contract

Appendix D

System Generated Reports

The overarching purpose of this set of reports is to enhance the quality of the encounter data by providing DHH-OBH and the PIHP with a basic accuracy and completeness assessment of each claim after each encounter cycle in order that preliminary corrections and repairs can be conducted and the encounter resubmitted to the FI. These reports will take advantage of the existing MMIS reporting capacity for claims data. However, the reports are altered, as necessary, to enhance their usefulness in depicting encounter data errors.

Encounter data is submitted through the FI's Electronic Data Interchange (EDI) and undergoes a series of 837 COB edits, passing through to the MMIS, and then going through a set of edits that will result in summary and repairable edit codes reports and a summary report of the encounter data submitted. These edit codes are listed in Appendix D of this Guide. Those edit codes that assess encounters to be repairable for correction and resubmission by the PIHP are found in Section 6 of this Guide.

The following reports are generated by the MMIS system and have been selected specifically to provide the PIHP with useful information that, when compared with the 835 Remittance Advice for the specific encounter, will provide a complete explanation for the edit code. A second set of reports that focus more closely on the overall quality of the data will also be created from the encounter data. These quality reports will also depict accuracy and completeness at a volume and utilization level.

ASC X12N 835

As discussed above, and in Section 5, the PIHP will receive an 835 for encounter data that has been processed through the MMIS if requested and arranged in advance. Adjustment reason code, adjustment amount, and adjustment quantity are returned via the CAS segment of loop 2110 if the service line fails MMIS encounter errors. CAS segments are also created for cutbacks to the submitted charge-for-fee schedule reductions, etc. All encounter data denials, including those that are repairable, are represented in the 835. TCNs are assigned by claim and can be located in the 835 specific to the encounter.

820 File (FI to PIHP)

See below.

Loop	Segment	Field	Description	Valuation	Derived Value (D), Column Map (M), Static Value (S)
ST=Transaction Set Header					
Sample: ST*820*0001*005010X218~					
	ST	ST01	Transaction Set Identifier Code	'820'	S
Remark: The transaction set control numbers in ST02 and SE02 must be identical. This number must be unique within a specific group and interchange, but the number can repeat in other groups and interchanges.					
		ST02	Transaction Set Control Number		
Remark: Identifying control number that must be unique within the transaction set functional group assigned by the originator for a transaction set. The Transaction Set Control Number in ST02 and SE02 must be identical. The number must be unique within a specific interchange (ISA-IEA), but can repeat in other interchanges.					
		ST03	Implementation Convention Reference	'005010X218'	S
Remark: This element must be populated with the guide identifier named in Section 1.2 of the IG. The unique Version/Release/Industry Identifier Code for transaction sets that are defined by this implementation guide is 005010X218. This field contains the same value as GS08. Some translator products strip off the ISA and GS segments prior to application (STSE) processing. Providing the information from the GS08 at this level will ensure that the appropriate application mapping is utilized at translation time.					
BPR=Financial Information					
Sample: BPR*I*950.00*C*NON******1726011595******20120209~					
	BPR	BPR01	Transaction Handling Code	I=Remittance Information Only	S
		BPR02	Monetary Amount	Total Premium Payment Amount	D
		BPR03	Credit/Debit Flag Code	C=Credit	S
		BPR04	Payment Method Code	NON	S
		BPR05	Payment Format Code	NOT USED	S
		BPR06	(DFI) ID Number Qualifier	NOT USED	S
Remark: Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier. SEMANTIC: BGN06 is the transaction set reference number of a previously sent transaction affected by the current transaction. SITUATIONAL RULE: Required when there is a previously sent transaction to cross-reference. If not required by this implementation guide, do not send.					
		BPR07	(DFI) Identification Number	NOT USED	S
		BPR08	Account Number Qualifier	NOT USED	S
		BPR09	Account Number		S
		BPR10	Originating Company Identifier	Federal tax ID number preceded by a 1.	S
		BPR11	Originating Company Supplemental Code	NOT USED	
		BRP12	(DFI) ID Number Qualifier	NOT USED	S
		BPR13	(DFI) Identification Number	NOT USED	S
		BRP14	Account Number Qualifier	NOT USED	S
		BPR15	Account Number		
		BPR16	EFT Effective Date	Expressed CCYYMMDD	

Loop	Segment	Field	Description	Valuation	Derived Value (D), Column Map (M), Static Value (S)
TRN=Reassociation Trace Number					
Sample: TRN*3*1123456789**~					
	TRN	TRN01	Trace Type Code	"3" – Financial Reassociation Trace Number. The payment and remittance information have been separated and need to be reassociated by the receiver.	S
		TRN02	Reference Identification	EFT Trace Number Used to reassociate payment with remittance information.	S
		TRN03	Originating Company Identifier	Must contain the Federal Tax ID number preceded by a 1 and must be identical to BPR10	S
REF=Premium Receiver's Identification Key					
Sample: REF*18*123456789* PIHP Fee Payment~					
		REF01	Reference Identification Qualifier	'18'=Plan Number	S
		REF02	Reference Identification	Premium Receiver Reference Identifier	
		REF03	Description	' PIHP Fee Payment'	S
DTM=Process Date					
Sample: DTM*009*20120103~					
		DTM01	Date/Time Qualifier	"009" – Process	S
		DTM02	Date	Payer Process Date CCYYMMDD	S
DTM=Delivery Date					
Sample: DTM*035*20120103~					
		DTM01	Date/Time Qualifier	"035" – Delivered	S
		DTM02	Date	Payer Process Date CCYYMMDD	S
DTM=Report Period					
Sample: DTM*582****RD8*20120101-20120131~					
		DTM01	Date/Time Qualifier	"582" – Report Period	S
		DTM02	Not Used	Not Used	
		DTM03	Not Used	Not Used	
		DTM04	Not Used	Not Used	
		DTM05	Date Time Period Qualifier	'RD8'	S

Loop	Segment	Field	Description	Valuation	Derived Value (D), Column Map (M), Static Value (S)
		DTM06	Date Time Period	Range of Dates Expressed in Format CCYYMMDD-CCYYMMDD	D
1000A PREMIUM RECEIVER'S NAME					
N1=Premium Receiver's Name					
Sample: N1*PE* PIHP of Louisiana*FI*1123456789~					
	1000A	N101	Entity ID Code	"PE" – Payee	
	1000A	N102	Name	Information Receiver Last or Organization Name	
	1000A	N103	Identification Code Qualifier	"FI" – Federal	
	1000A	N104	Identification Code	Receiver Identifier	
1000B PREMIUM PAYER'S NAME					
N1=Premium Payer's Name					
Sample: N1*PR*Louisiana Department of Health and Hospitals*FI*1123456789~					
	1000B	N101	Entity ID Code	"PR" – Payer	
	1000B	N102	Name	Premium Payer Name	
	1000B	N103	ID Code Qualifier	"FI" - Federal Taxpayer ID number	
	1000B	N104	Identification Code	Premium Payer ID	
2000B INDIVIDUAL REMITTANCE					
ENT=Individual Remittance					
Sample: ENT*1*2J*34*123456789~					
	2000B	ENT01	Assigned Number	Sequential Number assigned for differentiation within a transaction set	
	2000B	ENT02	Entity Identifier Code	"2J" - Individual	
	2000B	ENT03	Identification Code Qualifier	"34" - Social Security Number	
	2000B	ENT04	Identification Code	Individual Identifier - SSN	
2100B INDIVIDUAL NAME					
NM1=Policyholder Name					
Sample: NM1*QE*1*DOE*JOHN*Q***N*1234567890123~					
	2100B	NM101	Entity Identifier Code	"QE" - Policyholder (Recipient Name)	
	2100B	NM102	Policyholder	"1" - Person	

Loop	Segment	Field	Description	Valuation	Derived Value (D), Column Map (M), Static Value (S)
	2100B	NM103	Name Last	Individual Last Name	
	2100B	NM104	Name First	Individual First Name	
	2100B	NM105	Name Middle	Individual Middle Initial	
	2100B	NM106	NOT USED	NOT USED	
	2100B	NM107	NOT USED	NOT USED	
	2100B	NM108	Identification Code Qualifier	"N" – Insurer's Unique ID number	
	2100B	NM109	Identification Code	Recipient ID	
2300B INDIVIDUAL PREMIUM REMITTANCE DETAIL					
RMR=Organization Summary Remittance Detail					
Sample: RMR*AZ*1234567890123**400.00~					
	2300B	RMR01	Reference Identification Qualifier	"11" - Account Number	
	2300B	RMR02	Reference Identification	Claim ICN	
	2300B	RMR04	Monetary Amount	Detail Premium Payment Amount	
REF=Reference Information					
Sample: REF*ZZ*0101C~					
	2300B	REF01	Reference Identification Qualifier	"ZZ" - Mutually Identified	
	2300B	REF02	Reference Identification	Capitation Code	
	2300B	REF03	Not Used		
	2300B	REF04	Not Used		
DTM=Individual Coverage Period					
Sample: DTM*582****RD8*20120101-20120131~					
	2300B	DTM01	Date/Time Qualifier	"582" - Report Period	
	2300B	DTM02	NOT USED	NOT USED	
	2300B	DTM03	NOT USED	NOT USED	
	2300B	DTM04	NOT USED	NOT USED	
	2300B	DTM05	Date Time Period Format Qualifier	"RD8" – Range of Dates	
	2300B	DTM06	Date Time Period	Coverage Period, expressed as CCYYMMDD-CCYYMMDD	
Transaction Set Trailer					
Sample: SE*39*0001~					
	SE	SE01	Transaction Segment Count		
		SE02	Transaction Set Control Number		

Loop	Segment	Field	Description	Valuation	Derived Value (D), Column Map (M), Static Value (S)
Remark: The transaction set control numbers in ST02 and SE02 must be identical. This number must be unique within a specific group and interchange, but the number can repeat in other groups and interchanges.					

Appendix E

PIHP Generated Reports

The overarching purpose of this set of reports is to supplement information that is reported through the encounter process. Once the encounter process has stabilized, DHH may use encounters as the basis for these reports.

Denied Claims Report

DHH-OBH is interested in analyzing claims that are denied for the following reasons:

1. Lack of documentation to support Medical Necessity
2. Prior Authorization was not on file
3. Member has other insurance that must be billed first
4. Claim was submitted after the filing deadline
5. Service was not covered by the PIHP

In the future, DHH may elect to obtain additional denied claims information.

The PIHP is to submit to DHH-OBH an electronic report monthly on the number and type of denied claims referenced above **or the number and type of denied claims with a high occurrence (upward trend)**. The report shall include:

- Denial reason code including long description
- Claim type
- Missing documentation to support medical necessity
- Missing documentation of prior authorization (PA); e.g. no PA on file
- Date of service
- Date of receipt by PIHP
- Primary diagnosis
- Secondary diagnosis (if applicable)
- Procedure/HCPCS code(s)
- Surgical procedure code(s) (if applicable)
- Revenue code(s) (if applicable)
- Primary insurance carrier (if applicable)
- Primary insurance coverage begin date (if applicable)

FQHC and RHC Quarterly Report

The PIHP shall submit on a quarterly basis by date of service, a report of encounter/claim data of all contracting FQHCs and RHCs for State Plan required reconciliation purposes. The report shall include the following information:

- Name and NPI of Rendering Provider
- Name and NPI of Billing Provider
- Medicaid ID of recipient
- Date of Service
- Paid Date
- Billed Amount
- Paid Amount

Appendix F

Encounter Edit Codes

In order for data to be useful, the data must meet minimum thresholds of data quality. One of the most basic tests of data quality is editing. All encounter data submitted to the MMIS are subject to edits. Edits may post at the line or at the header. If an encounter denies at the header the encounter must be corrected and resubmitted. Instructions for correcting line level denials are found in Section 7 of this Guide.

Encounter data edits can have one of the following dispositions:

- Encounter passes all edits and is accepted into the MMIS and priced, per DHH guidelines (Pay),
- Encounter contains a fatal error that results in its rejection (Denial).

Below are tables for encounters set to information only (pay) and non-repairable denials. Please see Section 3 of this Guide for the edit codes that are repairable denials and instructions for correction and resubmission by the PIHP .

EDIT CODE	EDIT DISPOSITION – INFORMATION ONLY (E) EDIT DESCRIPTION
029	SERVICE MORE THAN 12 MONTHS OLD
030	SERVICE THRU DATE TOO OLD
084	TREATMENT PLACE INVALID
108	PROVIDER TYPE SERVICES NOT COVERED FOR RECIPIENT AGE
142	BILLING PROVIDER NPI MISSING/NOT ON FILE
143	SERVING PROVIDER NPI MISSING/NOT ON FILE
145	BILLING PROVIDER NPI MISMATCH
146	SERVICING PROVIDER NPI MISMATCH
201	PROVIDER NOT ELIGIBLE ON DATES OF SERVICE
207	BILLING PROVIDER INELIGIBLE ON DATE OF SERVICE
272	CLAIM EXCEEDS 1 YEAR FILING LIMIT
279	INVALID PLACE OF TREATMENT FOR PROF COMP
294	RECIPIENT NOT ON FILE RECYCLED 3 TIMES
295	RECIPIENT INELIGIBLE RECYCLED THREE TIMES
297	DECLARED BANKRUPTCY.FILE W/CARRIER FOR POSSIBLE PMTS.
330	QUALIFIED MEDICARE BENEFICIARY NOT MEDICAID ELIGIBLE
427	PSYCHIATRIC SERVICES NOT COVERED UNDER HOME HEALTH
546	Code added due to a REB of a current code only
550	MULTIPLE PROVIDERS WILL NOT BE PAID FOR THIS PROCEDURE

EDIT CODE	EDIT DISPOSITION – INFORMATION ONLY (E) EDIT DESCRIPTION
556	ATTENDING/SERVICING PROVIDER IS NOT LINKED TO PIHP (PIHP)
565	Added procedure has been denied as a duplicate procedure because the maximum allowed daily occurrences of this procedure was exceeded due to current codes.
584	Current procedure is flagged because the indicated procedure is inappropriate for patient's sex.
595	Current multi-unit line contains units, which have been denied for more than one reason. (Split-Decision)
596	Code added due to SPL claim
622	OUTPATIENT AND INPATIENT HOSPITAL SERVICES ON SAME DAY
651	HOSPITAL CUTBACK APPLIED
701	CONSULT FOLLOW-UP VISITS NOT ALLOWED.
711	SAME SPECIALTY/SUBSPECIALTY PAID ON SAME DATE OF SERV
715	FOUND DUPLICATE VISIT SAME DAY
727	EXCEEDS DAILY SERVICE MAXIMUM
730	ONE INP HOSP INITIAL/SUBSEQ CARE VISIT ALLOWED PER DAY
790	3 HOSPITAL INPATIENT SERV PAID FOR SAME DATE OF SERVICE
792	Bypass ClaimCheck edits
795	Bypass PAM edits
851	SUSPCT DUPLICATE ERROR: IDENTICAL HOSPITAL CLAIMS
855	SUSPCT DUPLICATE ERROR: IDENTICAL OUTPATIENT CLAIMS
863	SUSPCT DUPLICATE ERROR:IDENTICAL PHYSICIAN CLAIMS
918	MEDICAID ALLOWABLE AMOUNT REDUCED BY OTHER INSURANCE
919	MEDICAID ALLOWABLE AMOUNT REDUCED BY RECIPIENT SPENDOWN
921	UNITS DON'T MATCH THE SITE SPECIFIC MODIFIERS
947	E305 – MAXIMUM EXCEEEDED FOR ADDED CLAIM LINES. PLEASE SPLIT CLAIM AND RESUBMIT.
961	INVALID PROCEDURE-MODIFIER COMBINATION/CLAIMCHECK
962	MAXIMUM SERVICES EXCEEDED SAME DAY/CLAIMCHECK
964	Integration Wizard Defined AUDIT-RESULT
967	Integration Wizard Defined AUDIT-RESULT
969	Integration Wizard Defined AUDIT-RESULT
977	Integration Wizard Defined AUDIT-RESULT
978	CALCULATED PRICING IS ZERO/CALL HELP DESK
981	Integration Wizard Defined AUDIT-RESULT
029	SERVICE MORE THAN 12 MONTHS OLD
030	SERVICE THRU DATE TOO OLD
084	TREATMENT PLACE INVALID
108	PROVIDER TYPE SERVICES NOT COVERED FOR RECIPIENT AGE
142	BILLING PROVIDER NPI MISSING/NOT ON FILE
143	SERVING PROVIDER NPI MISSING/NOT ON FILE
145	BILLING PROVIDER NPI MISMATCH
146	SERVICING PROVIDER NPI MISMATCH
201	PROVIDER NOT ELIGIBLE ON DATES OF SERVICE
207	BILLING PROVIDER INELIGIBLE ON DATE OF SERVICE
272	CLAIM EXCEEDS 1 YEAR FILING LIMIT
279	INVALID PLACE OF TREATMENT FOR PROF COMP
294	RECIPIENT NOT ON FILE RECYCLED 3 TIMES
295	RECIPIENT INELIGIBLE RECYCLED THREE TIMES

EDIT CODE	EDIT DISPOSITION – INFORMATION ONLY (E) EDIT DESCRIPTION
297	DECLARED BANKRUPTCY.FILE W/CARRIER FOR POSSIBLE PMTS.
330	QUALIFIED MEDICARE BENEFICIARY NOT MEDICAID ELIGIBLE
427	PSYCHIATRIC SERVICES NOT COVERED UNDER HOME HEALTH
546	Code added due to a REB of a current code only
550	MULTIPLE PROVIDERS WILL NOT BE PAID FOR THIS PROCEDURE
556	ATTENDING/SERVICING PROVIDER IS NOT LINKED TO PIHP (PIHP)
565	Added procedure has been denied as a duplicate procedure because the maximum allowed daily occurrences of this procedure was exceeded due to current codes.
584	Current procedure is flagged because the indicated procedure is inappropriate for patient's sex.
595	Current multi-unit line contains units, which have been denied for more than one reason. (Split-Decision)
596	Code added due to SPL claim
622	OUTPATIENT AND INPATIENT HOSPITAL SERVICES ON SAME DAY
651	HOSPITAL CUTBACK APPLIED
701	CONSULT FOLLOW-UP VISITS NOT ALLOWED.
711	SAME SPECIALTY/SUBSPECIALTY PAID ON SAME DATE OF SERV
715	FOUND DUPLICATE VISIT SAME DAY
727	EXCEEDS DAILY SERVICE MAXIMUM
730	ONE INP HOSP INITIAL/SUBSEQ CARE VISIT ALLOWED PER DAY
790	3 HOSPITAL INPATIENT SERV PAID FOR SAME DATE OF SERVICE
792	Bypass ClaimCheck edits
795	Bypass PAM edits
851	SUSPCT DUPLICATE ERROR: IDENTICAL HOSPITAL CLAIMS
855	SUSPCT DUPLICATE ERROR: IDENTICAL OUTPATIENT CLAIMS
863	SUSPCT DUPLICATE ERROR:IDENTICAL PHYSICIAN CLAIMS
918	MEDICAID ALLOWABLE AMOUNT REDUCED BY OTHER INSURANCE
919	MEDICAID ALLOWABLE AMOUNT REDUCED BY RECIPIENT SPENDOWN
921	UNITS DON'T MATCH THE SITE SPECIFIC MODIFIERS
947	E305 – MAXIMUM EXCEEEDED FOR ADDED CLAIM LINES. PLEASE SPLIT CLAIM AND RESUBMIT.
961	INVALID PROCEDURE-MODIFIER COMBINATION/CLAIMCHECK
962	MAXIMUM SERVICES EXCEEDED SAME DAY/CLAIMCHECK
964	Integration Wizard Defined AUDIT-RESULT
967	Integration Wizard Defined AUDIT-RESULT
969	Integration Wizard Defined AUDIT-RESULT
977	Integration Wizard Defined AUDIT-RESULT
978	CALCULATED PRICING IS ZERO/CALL HELP DESK
981	Integration Wizard Defined AUDIT-RESULT

EDIT CODE	EDIT DISPOSITION - NON REPAIRABLE DENIALS EDIT DESCRIPTION
117	MAXIMUM OF 2 DAYS ALLOWED TO TRANSFER MHISA PATIENTS
210	PROVIDER NOT CERTIFIED FOR THIS PROCEDURE
219	EPSDT REFERRAL FOR RECIPIENT OVER 21 years old
222	RECIPIENT INELIGIBLE ON ONE OR MORE SERVICE DATE(S)
231	NDC IS NOT ON THE PROCUDURE FORMULARY FILE

EDIT CODE	EDIT DISPOSITION - NON REPAIRABLE DENIALS EDIT DESCRIPTION
233	PROCEDURE/NDC NOT COVERED FOR SERVICE DATE GIVEN
234	PROCEDURE/NDC NOT COVERED FOR AGE GIVEN
237	PROCEDURE/NDC NOT COVERED FOR PROVIDER SPECIALTY GIVEN
293	RECYCLED RECIPIENT INELIGIBLE ON DOS
299	PROCEDURE/DRUG NOT COVERED BY MEDICAID
367	ADJUSTMENT DENIED/ORIG CLAIM PAID CORRECTLY
508	WAIVER SVC NOT PAYABLE WHILE IP
528	LACHIP AFFORDABLE PLAN - SUBMIT CLAIM TO LOUISIANA OFFICE OF GROUP BENEFITS
530	RECIPIENT WAS REIMBURSED FOR THIS SERVICE
631	EPSDT AGE OVER 21
642	ONLY 1 INITIAL CONSULT-SAME PHYS.PER HOSPITALIZATION
644	VISIT CODE ALREADY PAID FOR THIS DATE OF SERVICE
673	EVAL AND MGT CODE PAID FOR THIS DOS
689	MHR SERVICES ALREADY PAID FOR THIS DATE OF SERVICE
695	ONE HOSPITAL DISCHARGE SERVICE PAID PER ADMISSION
704	ER VISIT ON DATE OF INP HOS SERVICES
712	ONE INITIAL HOSPITAL INPATIENT SERVICE PAID PER ADMISS
716	PROCEDURE INCLUDED IN THE PHYSICIAN OFFICE VISIT
735	PREVIOUSLY PAID ANES.OR SUPERVISING ANES SAME RECI/DOS
746	SAME ATTENDING PROV PAID INPT CONSULTATION SAME STAY
758	FOUND DUPLICATE SERVICE SAME DAY
791	BILLED CODE CONFLICTS WITH CODE ALREADY PAID
794	INPT HOSP SERV PAID FOR SAME DOS TO SAME ATTENDING PROV
797	DUPLICATE ADJUSTMENT RECORDS ENTERED
798	HISTORY RECORD ALREADY ADJUSTED
800	DUPLICATE OF PREVIOUSLY PAID CLAIM
801	EXACT DUPLICATE ERROR: IDENTICAL HOSPITAL CLAIMS
802	EXACT DUPLICATE ERROR: HOSPITAL AND TITLE18-INSTITUTION
805	EXACT DUPLICATE ERROR: IDENTICAL OUTPATIENT CLAIMS
806	EXACT DUPLICATE ERROR: OUTPATIENT AND REHAB SERVICES
813	EXACT DUPLICATE ERROR: IDENTICAL PHYSICIAN CLAIMS
814	EXACT DUPLICATE ERROR: PHYSICIAN AND TITLE18
849	ALREADY PAID SAME ATTENDING DIFFERENT BILLING PROVIDER
898	EXACT DUPE SAME ICN - DROPPED
926	EXACT DUPLICATE OF ANOTHER ADJUSTMENT.
942	DENIED BY MEDICARE NOT COVERED BY MEDICAID
948	INCLUDED IN MAJOR SURGICAL PROCEDURE
951	DATE OF DISCHARGE NOT COVERED
952	INCLUDED IN OFFICE VISIT/RELATED PROCEDURE
954	INAPPROPRIATE PROCEDURE - SEE CPT FOR VALID CODE
972	ALLOWABLE AMOUNT PAID IN FULL BY MEDICARE
117	MAXIMUM OF 2 DAYS ALLOWED TO TRANSFER MHISA PATIENTS
210	PROVIDER NOT CERTIFIED FOR THIS PROCEDURE
219	EPSDT REFERRAL FOR RECIPIENT OVER 21 years old
222	RECIPIENT INELIGIBLE ON ONE OR MORE SERVICE DATE(S)

EDIT CODE	EDIT DISPOSITION - NON REPAIRABLE DENIALS EDIT DESCRIPTION
231	NDC IS NOT ON THE PROCUDURE FORMULARY FILE
233	PROCEDURE/NDC NOT COVERED FOR SERVICE DATE GIVEN
234	PROCEDURE/NDC NOT COVERED FOR AGE GIVEN
237	PROCEDURE/NDC NOT COVERED FOR PROVIDER SPECIALTY GIVEN
293	RECYCLED RECIPIENT INELIGIBLE ON DOS
299	PROCEDURE/DRUG NOT COVERED BY MEDICAID
367	ADJUSTMENT DENIED/ORIG CLAIM PAID CORRECTLY
508	WAIVER SVC NOT PAYABLE WHILE IP
528	LACHIP AFFORDABLE PLAN - SUBMIT CLAIM TO LOUISIANA OFFICE OF GROUP BENEFITS
530	RECIPIENT WAS REIMBURSED FOR THIS SERVICE
631	EPSDT AGE OVER 21
642	ONLY 1 INITIAL CONSULT-SAME PHYS.PER HOSPITALIZATION
644	VISIT CODE ALREADY PAID FOR THIS DATE OF SERVICE
673	EVAL AND MGT CODE PAID FOR THIS DOS
689	MHR SERVICES ALREADY PAID FOR THIS DATE OF SERVICE
695	ONE HOSPITAL DISCHARGE SERVICE PAID PER ADMISSION
704	ER VISIT ON DATE OF INP HOS SERVICES
712	ONE INITIAL HOSPITAL INPATIENT SERVICE PAID PER ADMISS
716	PROCEDURE INCLUDED IN THE PHYSICIAN OFFICE VISIT
735	PREVIOUSLY PAID ANES.OR SUPERVISING ANES SAME RECI/DOS
746	SAME ATTENDING PROV PAID INPT CONSULTATION SAME STAY
758	FOUND DUPLICATE SERVICE SAME DAY
791	BILLED CODE CONFLICTS WITH CODE ALREADY PAID
794	INPT HOSP SERV PAID FOR SAME DOS TO SAME ATTENDING PROV
797	DUPLICATE ADJUSTMENT RECORDS ENTERED
798	HISTORY RECORD ALREADY ADJUSTED
800	DUPLICATE OF PREVIOUSLY PAID CLAIM
801	EXACT DUPLICATE ERROR: IDENTICAL HOSPITAL CLAIMS
802	EXACT DUPLICATE ERROR: HOSPITAL AND TITLE18-INSTITUTION
805	EXACT DUPLICATE ERROR: IDENTICAL OUTPATIENT CLAIMS
806	EXACT DUPLICATE ERROR: OUTPATIENT AND REHAB SERVICES
813	EXACT DUPLICATE ERROR: IDENTICAL PHYSICIAN CLAIMS
814	EXACT DUPLICATE ERROR: PHYSICIAN AND TITLE18
849	ALREADY PAID SAME ATTENDING DIFFERENT BILLING PROVIDER
898	EXACT DUPE SAME ICN - DROPPED
926	EXACT DUPLICATE OF ANOTHER ADJUSTMENT.
942	DENIED BY MEDICARE NOT COVERED BY MEDICAID
948	INCLUDED IN MAJOR SURGICAL PROCEDURE
951	DATE OF DISCHARGE NOT COVERED
952	INCLUDED IN OFFICE VISIT/RELATED PROCEDURE
954	INAPPROPRIATE PROCEDURE - SEE CPT FOR VALID CODE
972	ALLOWABLE AMOUNT PAID IN FULL BY MEDICARE

The table below represents the edit codes that may be corrected by the PIHP :

EDIT CODE	EDIT DISPOSITION – DENY (REPAIRABLE OR REPAIRABLE UNDER LIMITED CIRCUMSTANCES)[3] EDIT DESCRIPTION
001	INVALID CLAIM TYPE MODIFIER
002	INVALID PROVIDER NUMBER
003	INVALID RECIPIENT NUMBER
005	INVALID STATEMENT FROM DATE
006	INVALID STATMENT THRU DATE
007	SERVICE THRU DATE LESS THAN SERVICE FROM DATE
008	SERVICE FROM DATE LATER THAN DATE PROCESSED
009	SERVICE THRU DATE GREATER THAN DATE OF ENTRY
012	ORIGINAL CLAIM WITH AN ADJUSTMENT OR VOID REASON CODE
013	ORIGINAL CLAIM WITH AN ADJUSTMENT OR VOID ICN
015	ACCIDENT INDICATOR MUST BE Y N SPACE
016	ACCIDENT INDICATOR NOT Y N OR SPACE
017	EPSDT INDICATOR NOT Y N OR SPACE
023	RECIPIENT NAME IS MISSING
024	BILLING PROVIDER NUMBER NOT NUMERIC
026	TOTAL DOCUMENT CHARGE MISSING OR NOT NUMERIC
028	INVALID MISSING PROCEDURE CODE
040	ADMISSION DATE MISSING OR INVALID
043	INVALID ATTENDING PHYSICIAN
045	PATIENT STATUS CODE INVALID OR MISSING
046	PATIENT STATUS DATE MISSING OR INVALID
047	PATIENT STATUS DATE GREATER THAN THRU DATE
055	ACCOMMODATION/ANCILLARY CHARGE MISSING OR INVALID
063	THE TOTAL HOSPITAL CHARGE IS NOT NUMERIC
064	THE NET BILLED AMOUNT IS NOT NUMERIC
065	THE SIGNATURE INDICATOR MUST BE Y, N, OR BLANK
069	INVALID OCCURRENCE DATE
071	STATEMENT COVERS FROM DATE INVALID
072	STATEMENT COVERS THRU DATE INVALID
073	STATEMENT COVERS FROM DATE LESS THAN SERVICE FROM DATE
074	STATEMENT COVERS THRU DATE IS GREATER THAN SERVICE THRU
081	INVALID OR MISSING PATIENT STATUS DATE
082	INVALID PATIENT STATUS CODE
085	INVALID OR MISSING UNITS VISITS AND STUDIES

[3] These denials may be corrected or corrected only in some instances

EDIT CODE	EDIT DISPOSITION – DENY (REPAIRABLE OR REPAIRABLE UNDER LIMITED CIRCUMSTANCES)[3] EDIT DESCRIPTION
093	REVENUE CODE MISSING/INVALID
095	CONDITION CODE 40 FROM THROUGH NOT EQUAL
096	REVENUE CHARGE MISSING OR INVALID
097	NON-COVERED CHARGES EXCEED BILLED CHARGES
098	BILL CLASS 2 REQUIRES MEDICARE ALLOWED AMOUNT IN LOC#54
101	INVALID EMERGENCY INDICATOR
114	INVALID OR MISSING HCPCS CODE
115	HCPCS CODE NOT ON FILE
120	QUANTITY INVALID/MISSING
127	NDC INVALID/MISSING
131	PRIMARY DIAGNOSIS NOT ON FILE
180	THE ADMISSION DATE WAS NOT A VALID DATE
183	SURGICAL PROCEDURE NOT ON FILE
186	CERTIFIED REGISTERED NURSE ANESTHETISTS MUST BILL CORRECT MODIFIER
206	BILLING PROVIDER NOT ON FILE
211	DATE OF SERVICE LESS THAN DATE OF BIRTH
215	RECIPIENT NOT ON FILE
260	ANESTHESIA BASE UNITS ARE NOT ON FILE
269	ANESTHESIOLOGIST CPT NOT COVERED FOR MEDICAID ONLY-BILL SURG+MOD
273	3RD PARTY CARRIER CODE MISSING; REFER TO CARRIER CODE LIST
289	INVALID PROVIDER NUMBER WHEN DENY APPLIED
301	EMERGENCY ACCESS HOSPITAL - NATURE OF ADMISSION MUST BE EMERGENCY
307	SURGICAL PROCEDURE MISSING
309	DATE OF SURGERY MISSING
310	DATE OF SURGERY LESS THAN SERVICE FROM DATE
311	DATE OF SURGERY GREATER THAN SERVICE THRU DATE
376	ADJUSTMENT DAYS CONFLICT WITH HISTORY DAYS
430	MODIFIER NOT NEEDED-REMOVE AND RESUBMIT
444	MISSING/INVALID SERVICE PROVIDER
506	SUBMITTING PROVIDER IS NOT A CCN (PIHP)
513	HCPCS REQUIRED
539	CLAIM REQUIRES DETAILED BILLING
702	NEW PATIENT/ESTABLISHED PATIENT CODE CONFLICT
796	ORIG/ADJ BILLING PROVIDER NUMBER DIFFERENT
799	NO HISTORY RECORD ON FILE FOR THIS ADJUSTMENT

EDIT CODE	EDIT DISPOSITION – DENY (REPAIRABLE OR REPAIRABLE UNDER LIMITED CIRCUMSTANCES)[3] EDIT DESCRIPTION
914	UNITS DO NOT MATCH DATES OF SERVICE/CLAIMCHECK
930	BILL ONE PROCEDURE PER LINE FOR EACH DATE OF SERVICE
931	DENIED PER THE TPL EOB INFORMATION
933	INVALID/MODIFIER/PROCEDURE CODE COMBINATION
946	SPLIT BILL FOR PARTIAL ELIGIBILITY.
949	ANESTHESIA MINUTES INVALID OR MISSING
980	INVALID ADJUSTMENT REASON
983	SYSTEM CALCULATED TOTAL - NET BILLED NOT IN BALANCE

Appendix G

Provider Directory/Network Provider and Sub Registry

The PIHP will be required to provide DHH-OBH with a list of contracted providers including various data elements that are publicly available from NPPES through the Freedom of Information Act (FOIA). DHH-OBH shall be provided advance copies of all updates not less than ten (10) working days in advance of distribution. Any providers no longer taking patients must be clearly identified. Under the FOIA, CMS allowed disclosure of NPPES health care provider data available beginning Tuesday, September 4, 2007. The NPI Registry became operational on September 4th and CMS posted the downloadable file on September 12th, 2007.

At the onset of the PIHP Contract and weekly thereafter, the PIHP should submit to Molina an updated provider directory/registry.

The following file layout describes the data characteristics and structure of the Provider Registry File as it should be submitted by the PIHP to Molina. This file layout is followed by the MMIS allowed Provider Types and Provider Specialties.

Provider Registry File Layout

Column(s)	Item	Notes	Length	Format	R=Required O=Optional
NOTE: This record format describes a fixed-format layout. The record size is fixed at 750 bytes. If a field is listed as Optional (O), and the PIHP elects not to populate the field, then it should be filled with blanks or zeros as appropriate to the Length and Format definition (character or numeric, respectively).					
1-20	NPI	National Provider ID number	20	First 10 characters should represent the NPI. Last 10 characters should be spaces. If the number has leading zeroes, be sure to include them.	R
21	Delimiter		1	Character, use the ^ character value	
22	Entity Type code	1=Individual, 2=Organization	1		R

Column(s)	Item	Notes	Length	Format	R=Required O=Optional
23	Delimiter		1	Character, use the ^ character value	
24-43	Replacement NPI	DO NOT USE AT THIS TIME. FOR FUTURE USE.	20	First 10 characters should represent the NPI. Last 10 characters should be spaces. If the number has leading zeroes, be sure to use them.	O
44	Delimiter		1	Character, use the ^ character value	
45-74	Provider Name OR the Legal Business Name for Organizations. If the entity type=1 (individual), please format the name in this manner: First 13 positions= provider first name, 14th position=middle initial (or space), 15-27th characters=last name, 28-30th positions=suffix. If names do not fit in these positions, please truncate the end of the item so that it fits in the positions.		30	Character	R
75	Delimiter		1	Character, use the ^ character value	
76-105	Provider Business Mailing Address (First line address)		30	Character	R

Column(s)	Item	Notes	Length	Format	R=Required O=Optional
106	Delimiter		1	Character, use the ^ character value	
107-136	Provider Business Mailing Address (Second line address)		30	Character	O
137	Delimiter		1	Character, use the ^ character value	
138-167	Provider Business Mailing Address (City,)		30	Character	R
168	Delimiter		1	Character, use the ^ character value	
169-170	Provider Business Mailing Address (State)	USPS state code abbreviation	2	Character	R
171	Delimiter		1	Character, use the ^ character value	
172-181	Provider Business Mailing Address (9-Digit Postal Code)		10	Character, left-justify, right-fill with spaces if necessary	R
182	Delimiter		1	Character, use the ^ character value	
183-192	Provider Business Mailing Address (Country Code if outside U.S.)	Leave blank if business mailing address is not outside the U.S.	10	Character, left-justify, right-fill with spaces if necessary	O
193	Delimiter		1	Character, use the ^ character value	
194-203	Provider Business Mailing Address (Telephone Number)	Do not enter dashes or parentheses.	10	Numeric	R
204	Delimiter		1	Character, use the ^ character value	
205-214	Provider Business Mailing Address (Fax Number)	Do not enter dashes or parentheses.	10	Numeric	O
215	Delimiter		1	Character, use the ^ character value	
216-245	Provider Business	No P.O. Box here, please use	30	Character	R

Column(s)	Item	Notes	Length	Format	R=Required O=Optional
	Location Address (First line address)	a physical address.			
246	Delimiter		1	Character, use the ^ character value	
247-276	Provider Business Location Address (Second line address)		30	Character	O
277	Delimiter		1	Character, use the ^ character value	
278-307	Provider Business Location Address (City,)		30	Character	R
308	Delimiter		1	Character, use the ^ character value	
309-310	Provider Business Location Address (State)		2	USPS state code abbreviation	R
311	Delimiter		1	Character, use the ^ character value	
312-321	Provider Business Location Address (Postal Code)		10	Character, left-justify, right-fill with spaces if necessary	R
322	Delimiter		1	Character, use the ^ character value	
323-332	Provider Business Location Address (Country Code if outside U.S)	Leave blank if business mailing address is not outside the U.S.	10	Character, left-justify, right-fill with spaces if necessary	O
333	Delimiter		1	Character, use the ^ character value	
334-343	Provider Business Location Address (Telephone Number)	Do not enter dashes or parentheses.	10	Numeric	R
344	Delimiter		1	Character, use the ^ character value	
345-354	Provider Business	Do not enter dashes or parentheses.	10	Numeric	O

Column(s)	Item	Notes	Length	Format	R=Required O=Optional
	Location Address (Fax Number)				
355	Delimiter		1	Character, use the ^ character value	
356-365	Healthcare Provider Taxonomy Code 1		10	Character	R Note: if a single NPI is used for multiple entities then we require at least 1 taxonomy per NPI. For example, if a single NPI is used for an acute care hospital as well as a DPPU in the hospital, then we need taxonomy for both units… each sent in a separate record.
366	Delimiter		1	Character, use the ^ character value	
367-376	Healthcare Provider Taxonomy Code 2	Use if necessary; otherwise leave blank.	10	Character	O
377	Delimiter		1	Character, use the ^ character value	
378-387	Healthcare Provider Taxonomy Code 3	Use if necessary; otherwise leave blank.	10	Character	O
388	Delimiter		1	Character, use the ^ character value	
389-395	Other Provider Identifier	If available, enter the provider's Louisiana Medicaid Provider ID	7	Numeric, left-fill with zeroes.	R, if provider is already enrolled with Medicaid; otherwise, optional.

Column(s)	Item	Notes	Length	Format	R=Required O=Optional
396	Delimiter		1	Character, use the ^ character value	
397-400	Other Provider Identifier Type Code	Provider Type and Provider Specialty	4	1st 2 characters are provider type; last 2 characters (3-4) are provider specialty. See PIHP Companion Guide for list of applicable provider types and specialties.	R
401	Delimiter		1	Character, use the ^ character value	
402-409	Provider Enumeration Date	NPPES enumeration date.	8	Numeric, format YYYYMMDD	R
410	Delimiter		1	Character, use the ^ character value	
411-418	Last Update Date	NPPES last update date; leave all zeros if not available.	8	Numeric, format YYYYMMDD	O
419	Delimiter		1	Character, use the ^ character value	
420-439	NPI Deactivation Reason Code	NPPES deactivation reason; leave blank if appropriate.	20	Left justify, right-fill with spaces.	O
440	Delimiter		1	Character, use the ^ character value	
441-448	NPI Deactivation Date	NPPES deactivation date; leave all zeros if not appropriate.	8	Numeric, format YYYYMMDD	O
449	Delimiter		1	Character, use the ^ character value	
450-457	NPI Reactivation Date	NPPES reactivation date; leave all zeros if not appropriate.	8	Numeric, format YYYYMMDD	O
458	Delimiter		1	Character, use the ^ character value	
459	Provider Gender Code	M=Male, F=Female,	1	Character .	R

Column(s)	Item	Notes	Length	Format	R=Required O=Optional
		N=Not applicable			
460	Delimiter		1	Character, use the ^ character value	
461-480	Provider License Number		20	Character, left-justified, right-fill with spaces.	R
481	Delimiter		1	Character, use the ^ character value	
482-483	Provider License Number State Code	2-character USPS state code value	2	Character	R
484	Delimiter		1	Character, use the ^ character value	
485-534	Authorized Official Contact Information (First Name, Middle Name, Last Name)		50	Character, left-justified, right-fill with spaces.	R
535	Delimiter		1	Character, use the ^ character value	
536-565	Authorized Official Contact Information (Title or Position)		30	Character, left-justified, right-fill with spaces.	O
566	Delimiter		1	Character, use the ^ character value	
567-576	Authorized Official Contact Information (Telephone Number)	Do not enter dashes or parentheses.	10	Numeric	R
577	Delimiter		1	Character, use the ^ character value	
578	Panel Open Indicator	Y=Yes, panel is open. N=No, panel is not open.	1	Character	R for PCPs; otherwise optional.
579	Delimiter		1	Character, use the ^ character value	
580	Language Indicator 1 (this is the primary language indicator)	1=English-speaking patients only	1	Character	R for PCPs, specialists and other professionals;

Column(s)	Item	Notes	Length	Format	R=Required O=Optional
		2=Accepts Spanish-speaking patients 3=Accepts Vietnamese-speaking patients 4=Accepts French-speaking patients 5=Accepts Cambodian-speaking patients			otherwise optional.
581	Delimiter		1	Character, use the ^ character value	
582	Language Indicator 2 (this is a secondary language indicator)	0=no other language supported 1= Accepts English-speaking patients 2=Accepts Spanish-speaking patients 3=Accepts Vietnamese-speaking patients 4=Accepts French-speaking patients 5=Accepts Cambodian-speaking patients	1	Character	O
583	Delimiter		1	Character, use the ^ character value	
584	Language Indicator 3 (this is a secondary language indicator)	0=no other language supported 1=English-speaking patients only 2=Accepts Spanish-speaking patients 3=Accepts Vietnamese-speaking patients	1	Character	O

Column(s)	Item	Notes	Length	Format	R=Required O=Optional
		4=Accepts French-speaking patients 5=Accepts Cambodian-speaking patients			
585	Delimiter		1	Character, use the ^ character value	
586	Language Indicator 4 (this is a secondary language indicator)	0=no other language supported 1=English-speaking patients only 2=Accepts Spanish-speaking patients 3=Accepts Vietnamese-speaking patients 4=Accepts French-speaking patients 5=Accepts Cambodian-speaking patients	1	Character	O
587	Delimiter		1	Character, use the ^ character value	
588	Language Indicator 5 (this is a secondary language indicator)	0=no other language supported 1=English-speaking patients only 2=Accepts Spanish-speaking patients 3=Accepts Vietnamese-speaking patients 4=Accepts French-speaking patients 5=Accepts Cambodian-speaking patients	1	Character	O
589	Delimiter		1	Character, use the ^ character value	

Column(s)	Item	Notes	Length	Format	R=Required O=Optional
590	Age Restriction Indicator	0=no age restrictions 1=adult only 2=pediatric only	1	Character	R for PCPs, specialists and other professionals; otherwise optional.
591	Delimiter		1	Character, use the ^ character value	
592-596	PCP Linkage Maximum	Numeric	5	Numeric, left fill with zeroes. This number represents the maximum number of patients that can be linked to the PCP. It should be left all zeroes if the provider is not a PCP/specialist.	R for PCPs; otherwise optional.
597	Delimiter		1	Character, use the ^ character value	
598-602	PCP Linkages with PIHP	Numeric	5	Numeric, left fill with zeroes. This number represents the maximum number of PIHP enrollees that can be linked to the PCP. It should be left all zeroes if the provider is not a PCP/specialist.	R for PCPs; otherwise optional.
603	Delimiter		1	Character, use the ^ character value	
604-608	PCP Linkages with Others	Numeric	5	Numeric, left fill with zeroes. This number represents the maximum number of enrollees in other plans (not PIHP) that can be linked to the PCP. It should be left all zeroes if the provider is not a PCP/specialist.	R for PCPs; otherwise optional.
609	Delimiter		1	Character, use the ^ character value	

Column(s)	Item	Notes	Length	Format	R=Required O=Optional
610	PIHP Enrollment Indicator	N=New enrollment C=Change to existing enrollment D=Disenrollment	1	Use this field to identify new providers, changes to existing providers, and disenrolled providers	R
611	Delimiter		1	Character, use the ^ character value	
612-619	PIHP Enrollment Indicator Effective Date	Effective date of Enrollment Indicator above.	8	Numeric, format YYYYMMDD	R
620	Delimiter		1	Character, use the ^ character value	
621	Family Only Indicator	0=no restrictions 1=family members only	1		R for PCPs; otherwise optional.
622	Delimiter		1	Character, use the ^ character value	
623-624	Provider Sub-Specialty 1	Value set is determined by DHH and is available in PIHP Companion Guide	2		R for PCPs; otherwise optional
625	Delimiter		1	Character, use the ^ character value	
626-627	Provider Sub-Specialty 2	If necessary, Value set is determined by DHH and is available in PIHP Companion Guide	2		O
628	Delimiter		1	Character, use the ^ character value	
629-630	Provider Sub-Specialty 3	If necessary, Value set is determined by DHH and is available in PIHP Companion Guide	2		O

Column(s)	Item	Notes	Length	Format	R=Required O=Optional
631	Delimiter		1	Character, use the ^ character value	
632-661	PIHP Contract Name or Number	This should represent the contract name/number that is established between the PIHP and the Provider	30	Character	R
662	Delimiter		1	Character, use the ^ character value	
663-670	PIHP Contract Begin Date	Date that the contract between the PIHP and the provider started	8	Numeric date value in the form YYYYMMDD	R
671	Delimiter		1	Character, use the ^ character value	
672-679	PIHP Contract Term Date	Date that the contract between the PIHP and the provider was terminated.	8	Numeric date value in the form YYYYMMDD	O
680	Delimiter		1	Character, use the ^ character value	
681-682	Provider Parish served – 1st or primary	Parish code value that represents the primary parish that the provider serves	2	2-digit parish code value. See the PIHP Companion Guide.	R
683	Delimiter		1	Character, use the ^ character value	
684-685	Provider Parish served – 2nd	Parish code value that represents a secondary or other parish that the provider serves. Use only if necessary; otherwise enter 00.	2	2-digit parish code value. See the PIHP Companion Guide.	O
686	Delimiter		1	Character, use the ^ character value	

Column(s)	Item	Notes	Length	Format	R=Required O=Optional
687-688	Provider Parish served – 3rd	Parish code value that represents a secondary or other parish that the provider serves. Use only if necessary; otherwise enter 00.	2	2-digit parish code value. See the PIHP Companion Guide.	O
689	Delimiter		1	Character, use the ^ character value	
690-691	Provider Parish served – 4th	Parish code value that represents a secondary or other parish that the provider serves. Use only if necessary; otherwise enter 00.	2	2-digit parish code value. See the PIHP Companion Guide.	O
692	Delimiter		1	Character, use the ^ character value	
693-694	Provider Parish served – 5th	Parish code value that represents a secondary or other parish that the provider serves. Use only if necessary; otherwise enter 00.	2	2-digit parish code value. See the PIHP Companion Guide.	O
695	Delimiter		1	Character, use the ^ character value	
696-697	Provider Parish served – 6th	Parish code value that represents a secondary or other parish that the provider serves. Use only if necessary;	2	2-digit parish code value. See the PIHP Companion Guide.	O

Column(s)	Item	Notes	Length	Format	R=Required O=Optional
		otherwise enter 00.			
698	Delimiter		1	Character, use the ^ character value	
699-700	Provider Parish served – 7th	Parish code value that represents a secondary or other parish that the provider serves. Use only if necessary; otherwise enter 00.	2	2-digit parish code value. See the PIHP Companion Guide.	O
701	Delimiter		1	Character, use the ^ character value	
702-703	Provider Parish served – 8th	Parish code value that represents a secondary or other parish that the provider serves. Use only if necessary; otherwise enter 00.	2	2-digit parish code value. See the PIHP Companion Guide.	O
704	Delimiter		1	Character, use the ^ character value	
705-706	Provider Parish served – 9th	Parish code value that represents a secondary or other parish that the provider serves. Use only if necessary; otherwise enter 00.	2	2-digit parish code value. See the PIHP Companion Guide.	O
707	Delimiter		1	Character, use the ^ character value	
708-709	Provider Parish served – 10th	Parish code value that represents a secondary or other parish that	2	2-digit parish code value. See the PIHP Companion Guide.	O

Column(s)	Item	Notes	Length	Format	R=Required O=Optional
		the provider serves. Use only if necessary; otherwise enter 00.			
710	Delimiter		1	Character, use the ^ character value	
711-712	Provider Parish served – 11th	Parish code value that represents a secondary or other parish that the provider serves. Use only if necessary; otherwise enter 00.	2	2-digit parish code value. See the PIHP Companion Guide.	O
713	Delimiter		1	Character, use the ^ character value	
714-715	Provider Parish served – 12th	Parish code value that represents a secondary or other parish that the provider serves. Use only if necessary; otherwise enter 00.	2	2-digit parish code value. See the PIHP Companion Guide.	O
716	Delimiter		1	Character, use the ^ character value	
717-718	Provider Parish served – 13th	Parish code value that represents a secondary or other parish that the provider serves. Use only if necessary; otherwise enter 00.	2	2-digit parish code value. See the PIHP Companion Guide.	O
719	Delimiter		1	Character, use the ^ character value	

Column(s)	Item	Notes	Length	Format	R=Required O=Optional
720-721	Provider Parish served – 14th	Parish code value that represents a secondary or other parish that the provider serves. Use only if necessary; otherwise enter 00.	2	2-digit parish code value. See the PIHP Companion Guide.	O
722	Delimiter		1	Character, use the ^ character value	
723-724	Provider Parish served – 15th	Parish code value that represents a secondary or other parish that the provider serves. Use only if necessary; otherwise enter 00.	2	2-digit parish code value. See the PIHP Companion Guide.	O
725	Delimiter		1	Character, use the ^ character value	
726	Prescriber Indicator	Used for prescriber types: medical psychologists, physicians, psychiatrists, etc. Valid values are: **blank**=not applicable or no prescriptive authority. **0** = Full Rx Authority. **1** = Resident with Rx authority. **2** = Limited Rx authority (PA, NP, Medical Psychologist). **3** = Sanctioned. **4** = Full Rx authority plus ability to Rx Suboxone (opioid dependents). **5** = Pharmacist who can Rx Immunizations.	1	Character	R for prescriber types; otherwise leave blank.
727	Delimiter		1	Character, use the ^ character value	
728-749	Spaces	End of record filler	22	Enter all spaces	
750	End of record delimiter		1	Character, use the ^ character value	

DHH Valid Provider Types

The PIHP is required to populate the Provider Type field to a DHH valid provider type code as shown in the list below:

Provider Type and Description

Provider Type Code	Description
01	FISCAL AGENT (WVR)
02	TRANSITIONAL SUPPORT (WVR)
03	CHILDREN'S CHOICE (WVR)(IN-ST)
04	PEDI DAY HLTH CARE (IN-ST)
05	MANAGED CARE ORG - PREPAID
06	NOW PROFESSIONAL SERVICES
07	CASE MGMT-INFT & TODD (IN-ST)
08	OAAS CASE MGMT (IN-ST)
09	HOSPICE SERVICES (IN-ST)
10	COMPREHENSIVE COMM SUPPORT SRV
11	SHARED LIVING (WVR) (IN-ST)
12	MULTI-SYSTEMIC THER (IN-ST)
13	PREVOC REHAB (WVR) (IN-ST)
14	DAY HABILITAT (WVR) (IN-ST)
15	ENVIR ACC ADAP (WVR) (IN-ST)
16	PERS EMERG RESP SYS (WVR)
17	ASSISTIVE DEVICES (WVR)
18	COMM MENTAL HLTH CTR/PART HOSP
19	DR OF OSTEOPATH MED (IND & GP)
20	PHYSICIAN (IND & GP)
21	THIRD PARTY BILL AGT/SUBMITTER
22	PERSONAL CARE ATTENDANT (WVR)
23	INDEPENDENT LAB
24	PERSONAL CARE SERVICES (IN-ST)
25	MOBILE XRAY/RADIATION THRPY CT
26	PHARMACY
27	DENTIST (IND & GP)
28	OPTOMETRIST (IND & GP)
29	EARLYSTEPS (IND & GP) (IN-ST)
30	CHIROPRACTOR (IND & GP)
31	PSYCHOLOGIST (LIC/MED) (IN-ST)
32	PODIATRIST (IND & GP)
33	PRESCRIBING ONLY PROVIDER
34	AUDIOLOGIST (IN-ST)

35	PHYSICAL THERAPIST (IN-ST)
36	NOT ASSIGNED
37	OCCUPATIONAL THERAPIST (IN-ST)
38	SCHOOL BSED HEALTH CTR (IN-ST)
39	SPEECH/LANGUAGE THERAP (IN-ST)
40	DME
41	REGISTERED DIETICIAN (IN-ST)
42	NON-EMER MED TRANSPORT (IN-ST)
43	CASE MGT - NHV/FTM (IN-ST)
44	HOME HEALTH AGENCY (IN-ST)
45	CASE MGMT - CONTRACTOR (IN-ST)
46	CASE MGMT - HIV
47	CASE MGMT - CMI
48	CASE MGMT - PREGNANT WOMEN
49	CASE MGMT - DEVELOP DISABLED
50	PACE (ALL-INCLUSIVE CARE-ELD)
51	AMBULANCE TRANSPORTATION
52	CO-ORDIN CARE NETWORK-SHARED
53	SELF DIRECTED/DIRECT SUPPORT
54	AMBULATORY SURGI CTR (IN-ST)
55	EMERG ACCESS HOSPITAL (IN-ST)
56	PRESCRIBER ONLY FOR MCO
57	OPH REGISTERED NURSE (IN-ST)
58	NOT ASSIGNED
59	NEURO REHAB HOSPITAL (IN-ST)
60	HOSPITAL
61	VENERIAL DISEASE CL (IN-ST)
62	TUBERCULOSIS CLINIC
63	TUBERCULOSIS INPT HOSPITAL
64	MENTAL HLTH HOSP (FREE-STAND)
65	REHABILITATION CENTER (IN-ST)
66	KIDMED SCREENING CLINIC
67	PRENATAL HLTH CARE CL (IN-ST)
68	SUBS/ALCOH ABSE CTR (X-OVERS)
69	DIST PART PSYCH HOSP (IN-ST)
70	EPSDT HEALTH SERVICES (IN-ST)
71	FMLY PLANNING CLINIC (IN-ST)
72	FED QUALIFIED HLTH CTR (IN-ST)
73	LIC CL SOCIAL WORKER (IN-ST)
74	MENTAL HEALTH CLINIC (IN-ST)
75	OPTICAL SUPPLIER
76	HEMODIALYSIS CENTER (IN-ST)
77	MENTAL REHAB AGENCY (IN-ST)
78	NURSE PRACTITIONER (IND & GP)
79	RURAL HLTH CL(PROV-BSE)(IN-ST)
80	NURSING FACILITY (IN-ST)
81	CASE MGMT - VENT ASSTD CARE
82	PERS CARE ATTEND (WVR) (IN-ST)
83	CTR BASED RESPITE CARE (IN-ST)
84	SUBSTIT FMLY CARE (WVR)(IN-ST)

85	ADLT DAY HLTH CA (WVR) (IN-ST)
86	ICF/DD REHABILITATION
87	RURAL HLTH CL(INDEPEND)(IN-ST)
88	ICF/DD - GROUP HOME (IN-ST)
89	SPRVISE INDEP LIV (WVR)(IN-ST)
90	CERTIFIED NURSE MIDWIFE
91	CERT REG NURS ANEST (IND & GP)
92	PRIVATE DUTY NURSE
93	CLINICAL NURSE SPECIALIST
94	PHYSICIAN ASSISTANT
95	AMERICAN INDIAN/638 FACILITY
96	PSYCH RESID TREAT FACILITY
97	ADULT RESIDENTIAL CARE FAC
98	SUPPORTED EMPLYMENT (IN-ST)
99	GREAT NO COMM HLTH CONN(IN-ST)
AA	ASSERTIVE COMM TREAT TEAM
AB	PREPAID INPATIENT HLTH PLAN
AC	FAMILY SUPPORT ORGANIZATION
AD	TRANSITION COORDINATION
AE	RESPITE CARE SERVICE AGENCY
AF	CRISIS RECEIVING CENTER
AG	BEHAVIORAL HLTH REHAB AGENCY
AH	LIC MARRIAGE & FAMILY THERAPY
AJ	LICENSED ADDICTION COUNSELOR
AK	LICENSED PROFESSION COUNSELOR
AL	COMMUNITY CHOICE WAIVER-NURS
AM	HOME DELIVERED MEALS
AN	CAREGIVER TEMPORARY SUPPORT
AQ	NON-MEDICAL GROUP HOME
AR	THERAPEUTIC FOSTER CARE
AS	OPH CLINIC
AT	THERAPEUTIC GROUP HOME
AU	OPH REGISTERED DIETITIAN
AV	EXTENDED DUTY DENTAL ASSISTANT
AW	PERMANENT SUPPOR HOUSING AGENT
AX	CERTIFIED BEHAVIOR ANALYST
AY	DENTAL BENEFIT PLAN MANAGER
AZ	SUBST USE RESIDENT TX FAC
BC	BIRTH CENTER (FREE-STANDING)
BI	BEHAVIOR INTERVENTION
DC	DCFS TARGETED CASE MANAGEMENT
IP	EHR INCENTIVE PROGRAM
MI	MONITORED IN-HOME CAREGIVING
MW	LICENSED MID-WIFE
PO	PRESC ONLY/MCO RELATED
SP	SUPER PROVIDER/OHCDS
TS	TRANSPORTATION SUBCONTRACTOR

XX	ERROR PROVIDER

Provider Specialty Types

For providers registered as individual practitioners, DHH requires the MCO to assign a DHH provider specialty code from the DHH valid list of specialties found below

Specialty Code	Description	Type: 1=Specialty, 2=Subspecialty	Related Specialty (if Subspecialty)	Related Provider Types
00	All Specialties	1		n/a
01	General Practice	1		19,20
02	General Surgery	1		19, 20, 93
03	Allergy	1		19,20
04	Otology, Laryngology, Rhinology	1		19,20
05	Anesthesiology	1		19, 20, 91
06	Cardiovascular Disease	1		19,20
07	Dermatology	1		19,20
08	Family Practice	1		19, 20, 78
09	Gynecology (DO only)	1		19
10	Gastroenterology	1		19,20
11	Not in Use	n/a		n/a
12	Manipulative Therapy (DO only)	1		19
13	Neurology	1		19,20
14	Neurological Surgery	1		19,20
15	Obstetrics (DO only)	1		19
16	OB/GYN	1		19, 20, 78, 90
17	Ophthalmology, Otology, Laryngology, Rhinology (DO only)	1		19
18	Ophthalmology	1		20
19	Orthodontist	1		19,20
20	Orthopedic Surgery	1		19,20
21	Pathologic Anatomy; Clinical Pathology (DO only)	1		19
22	Pathology	1		20
23	Peripheral Vascular Disease or Surgery (DO only)	1		19
24	Plastic Surgery	1		19,20
25	Physical Medicine Rehabilitation	1		19,20
26	Psychiatry	1		19, 20, 93
27	Psychiatry; Neurology (DO only)	1		19
28	Proctology	1		19,20
29	Pulmonary Diseases	1		19,20
30	Radiology	1		19,20
31	Roentgenology, Radiology (DO only)	1		19

32	Radiation Therapy (DO only)	1		19
33	Thoracic Surgery	1		19,20
34	Urology	1		19,20
35	Chiropractor	1		30,35
36	Pre-Vocational Habilitation	1		13
37	Pediatrics	1		19, 20, 78
38	Geriatrics	1		19,20
39	Nephrology	1		19,20
40	Hand Surgery	1		19,20
41	Internal Medicine	1		19,20
42	Federally Qualified Health Centers	1		72
43	Not in Use	n/a		n/a
44	Public Health	1		66,70
45	NEMT - Non-profit	1		42
46	NEMT - Profit	1		42
47	NEMT - F+F	1		42
48	Podiatry - Surgical Chiropody	1		20, 32
49	Miscellaneous (Admin. Medicine)	1		20
50	Day Habilitation	1		14
51	Med Supply / Certified Orthotist	1		40
52	Med Supply / Certified Prosthetist	1		40
53	Direct Care Worker	1		40
54	Med Supply / Not Included in 51, 52, 53	1		40
55	Indiv Certified Orthotist	1		40
56	Indiv Certified Prosthetist	1		40
57	Indiv Certified Prosthetist - Orthotist	1		40
58	Indiv Not Included in 55, 56, 57	1		40
59	Ambulance Service Supplier, Private	1		51
60	Public Health or Welfare Agencies & Clinics	1		61, 62, 66, 67
61	Voluntary Health or Charitable Agencies	1		unknown
62	Psychologist Crossovers only	1		29, 31
63	Portable X-Ray Supplier (Billing Independently)	1		25
64	Audiologist (Billing Independently)	1		29,34
65	Indiv Physical Therapist	1		29,35
66	General Dentistry (DDS/DMS)	1		27
67	Oral and Maxillofacial Surgery	1		27
68	Pediatric Dentistry	1		27
69	Independent Laboratory (Billing Independently)	1		23
70	Clinic or Other Group Practice	1		19, 20, 68, 74, 76, 91
71	Speech Therapy	1		29
72	Diagnostic Laboratory	1		23
73	Social Worker Enrollment	1		73
74	Occupational Therapy	1		29,37
75	Other Medical Care	1		65

76	Adult Day Care	1		85
77	Habilitation	1		85
78	Mental Health Rehab	1		77
79	Nurse Practitioner	1		78
80	Environmental Accessibility Adaptations	1		15
81	Case Management	1		07, 08, 43, 46, 81
82	Personal Care Attendant	1		82
83	Respite Care	1		83
84	Substitute Family Care	1		84
85	Extended Care Hospital	1		60
86	Hospitals and Nursing Homes	1		55, 59, 60, 64, 69, 80, 88
87	All Other	1		26,40,44, 60
88	Optician / Optometrist	1		28,75
89	Supervised Independent Living	1		89
90	Personal Emergency Response Sys (Waiver)	1		16
91	Assistive Devices	1		17
92	Prescribing Only Providers/Providers Not Authorized to Bill Medicaid	1		33, 56, PO
93	Hospice Service for Dual Elig.	1		09
94	Rural Health Clinic	1		79,87
95	Psychologist (PBS Program Only)	1		31
96	Psychologist (PBS Program and X-Overs)	1		31
97	Family Planning Clinic	1		71
98	Supported Employment	1		98
99	Provider Pending Enrollment	1		n/a
1A	Adolescent Medicine	2	37	19,20
1B	Diagnostic Lab Immunology	2	37	19,20
1C	Neonatal Perinatal Medicine	2	37	19,20
1D	Pediatric Cardiology	2	37	19,20
1E	Pediatric Critical Care Medicine	2	37	19,20
1F	Pediatric Emergency Medicine	2	37	19,20
1G	Pediatric Endocrinology	2	37	19,20
1H	Pediatric Gastroenterology	2	37	19,20
1I	Pediatric Hematology - Oncology	2	37	19,20
1J	Pediatric Infectious Disease	2	37	19,20
1K	Pediatric Nephrology	2	37	19,20
1L	Pediatric Pulmonology	2	37	19,20
1M	Pediatric Rheumatology	2	37	19,20
1N	Pediatric Sports Medicine	2	37	19,20
1P	Pediatric Surgery	2	37	19,20
1Q	Pediatric Neurology	2	37	19,20
1R	Pediatric Genetics	2	37	19,20
1S	BRG - Med School	2		19,20
1T	Emergency Medicine	1		19,20

1U	Pediatric Developmental Behavioral Health	2	37	19,20
1Z	Pediatric Day Health Care	1		04
2A	Cardiac Electrophysiology	2	41	19,20
2B	Cardiovascular Disease	2	41	19,20
2C	Critical Care Medicine	2	41	19,20
2D	Diagnostic Laboratory Immunology	2	41	19,20
2E	Endocrinology & Metabolism	2	41	19,20
2F	Gastroenterology	2	41	19,20
2G	Geriatric Medicine	2	41	19,20
2H	Hematology	2	41	19,20
2I	Infectious Disease	2	41	19,20
2J	Medical Oncology	2	41	19,20
2K	Nephrology	2	41	19,20
2L	Pulmonary Disease	2	41	19,20
2M	Rheumatology	2	41	19,20
2N	Surgery - Critical Care	2	41	19,20
2P	Surgery - General Vascular	2	41	19,20
2Q	Nuclear Medicine	1		19,20
2R	Physician Assistant	1		94
2S	LSU Medical Center New Orleans	2		19,20
2T	American Indian / Native Alaskan	2		95
2Y	OPH Genetic Disease Program	1		40
3A	Critical Care Medicine	2	16	19,20
3B	Gynecologic oncology	2	16	19,20
3C	Maternal & Fetal Medicine	2	16	19,20
3D	Community Choices Waiver - Respiratory Therapy	2	87, 75	44, 65
3E	Community Choices Waiver - PT and OT	2	87, 75	44, 66
3F	Community Choices Waiver - PT and S/L T	2	87, 75	44, 67
3G	Community Choices Waiver - PT and RT	2	87, 75	44, 68
3H	Community Choices Waiver - OT and S/L T	2	87, 75	44, 69
3J	Community Choices Waiver - OT and RT	2	87, 75	44, 70
3K	Community Choices Waiver - S/L T and RT	2	87, 75	44, 71
3L	Community Choices Waiver - PT, OT & S/L T	2	87, 75	44, 72
3M	Community Choices Waiver - PT, OT & RT	2	87, 75	44, 73
3N	Community Choices Waiver - PT, S/L T & RT	2	87, 75	44, 74
3P	Organized Health Care Delivery System (OHCDS)	1		
3Q	Community Choices Waiver - OT, S/L T & RT	2	87, 75	44, 75
3R	Community Choices Waiver - All Skilled Maintenance Therapies (PT, OT, S/L T, RT)	2	87, 75	44, 76
3S	LSU Medical Center Shreveport	2		19,20
3T	DBPP - Dental Benefit Plan Prescriber	1		AY
3U	Community Choices Waiver – Assistive Devices – Home Health	2		
3W	Supportive Housing Agency	1		AW
3X	Extended Duty Dental Assistant	1		AV
3Y	DBPM - Dental Benefit Plan Management	1		AY
3Z	Transportation Subcontractor	1		TS

4A	Developmentally Disabled (DD)	1		01,02
4B	NOW RN	1		06
4C	NOW LPN	1		06
4D	NOW Psychologist	1		06
4E	NOW Social Worker	1		06
4G	New, Provider Domain	1		
4H	Conversion, Participant Domain	1		
4J	Conversion, Provider Domain	1		
4K	Home and Community-Based Services (HCBS)	1		
4L	New, Participant Domain	1		
4M	EHR Managed Care (Behavior Health)	2		IP
4P	OAAS	1		
4R	Registered Dietician	1		41
4S	Ochsner Med School	2		19,20
4U	OPH Registered Dietitian	1		AU
4W	Waiver Services	1		42
4X	Waiver-Only Transportation	1		42
4Y	EHR Managed Care (Medical)	2		IP
5A	PCS-LTC	1		24
5B	PCS-EPSDT	1		24
5C	PAS	1		24
5D	PCS-LTC, PCS-EPSDT	1		24
5E	PCS-LTC, PAS	1		24
5F	PCS-EPSDT, PAS	1		24
5G	PCS-LTC, PCS-EPSDT, PAS	1		24
5H	Community Mental Health Center			18
5I	Statewide Management Organization (SMO)	1		AB
5J	Youth Support	1		AC
5K	Family Support	1		AC
5L	Both Youth and Family Support	1		AC
5M	Multi-Systemic Therapy			12
5N	Substance Abuse and Alcohol Abuse Center	1		68
5P	PACE	1		50
5Q	CCN-P (Coordinated Care Network, Pre-paid)	1		05
5R	CCN-S (Coordinated Care Network, Shared Savings)	1		52
5S	Tulane Med School	2		19,20
5T	Community Choices Waiver (CCW)	1		
5U	Individual	1		AD
5V	Agency/Business	1		AD
5W	Community Choices Waiver - Personal Assistance Service	2	87	44
5X	Therapeutic Group Homes	1		AT
5Y	PRCS Addiction Disorder	1		
5Z	Therapeutic Group Home Disorder	1		
6A	Psychologist -Clinical	1		31
6B	Psychologist-Counseling	1		31
6C	Psychologist - School	1		31

6D	Psychologist - Developmental	1		31
6E	Psychologist - Non-Declared	1		31
6F	Psychologist - All Other	1		31
6G	Medical Psychologist	1		31
6H	LaPOP	1		01
6N	Endodontist	1		27
6P	Periodontist	1		27
6S	E Jefferson Fam Practice Ctr - Residency Program	2		19,20
6T	Community Choices Waiver - Physical Therapy	2	65, 87, 75	35, 44, 65
6U	Applied Behavioral Analyst	1		AX
6W	Licensed Mid-Wife	1		MW
7A	SBHC - NP - Part Time - less than 20 hrs week	1		38
7B	SBHC - NP - Full Time - 20 or more hrs week	1		38
7C	SBHC - MD - Part Time - less than 20 hrs week	1		38
7D	SBHC - MD - Full Time - 20 or more hrs week	1		38
7E	SBHC - NP + MD - Part Time - total = less than 20 hrs week	1		38
7F	SBHC - NP + MD - Full Time - total = 20 or more hrs week	1		38
7G	Community Choices Waiver - Speech/Language Therapy	2	71, 87, 75	39, 44, 65
7H	Community Choices Waiver - Occupational Therapy	2	74, 87, 75	37, 44, 65
7M	Retail Convenience Clinics	2	70	19,20,78
7N	Urgent Care Clinics	2	70	19,20,79
7P	ABA Therapy Psychologist	1		31
7R	Aquatic Therapy	1		31
7T	Art Therapy	1		31
7U	Art and Music	2		31
7V	Music Therapy	1		31
7X	Sensory Integration	1		31
7Y	Therapeutic Horseback Riding	1		31
7Z	Hippotherapy	1		31
7S	Leonard J Chabert Medical Center - Houma	2		19,20
8A	Elderly, Community Choices Waiver, DD	2	82	82
8B	Elderly, Community Choices Waiver	2	82	82
8C	DD services	2	82	82
8D	Community Choices Waiver - Caregiver Temporary Support	1	82, 83	82, 83
8E	CSoC/Behavioral Health	1, 2		AB, AC, AD, AE, AF, AG, AH, AJ, AK, 82, 31, 68, 70, 73, 83, 53
8F	Community Choices Waiver - Caregiver Temporary Support - Home Health	2	8D	AN
8G	Community Choices Waiver - Caregiver Temporary Support - Assisted Living	2	8D	AN
8H	Community Choices Waiver - Caregiver Temporary Support - ADHC	2	8D	AN
8J	Community Choices Waiver - Caregiver Temporary Support - Nursing Facility	2	8D	AN
8K	ADHC HCBS	1		AL
8L	Hospital-based PRTF	1		96

8M	Community Choices Waiver - Home-Delivered Meals	1		AM
8N	Community Choices Waiver - Nursing	2		44, 78
8O	IP - Doctor of Osteopathic Medicine	1		IP
8P	IP - Physician - MD	1		IP
8Q	EAA Assesor, Inspector, Approver	2		15
8R	PRTF, other Specialization	1		96
8S	OLOL Med School	2		
8U	Subst Abuse or Addiction	1		96
9A	Community Choices Waiver - Nursing and Personal Assistance Services	2		
9B	Psychiatric Residential Treatment Facility	1		96
9D	Residential Care	1		97
9E	Children's Choice Waiver	1		03
9F	Therapeutic Foster Care (TFC)	1		AR
9G	Non-Medical Group Home (NMGH)	1		AQ
9L	RHC/FQHC OPH Certified SBHC	1		72
9M	Monitored In-Home Caregiving (MIHC)	1		
9P	GNOCHC - Greater New Orleans Community Health Connection	1		99
9Q	PT 21 -Third-Party Biller/Submitter	2		21
9R	Electronic Visit Verification Submitter	2		21
9S	IP - Optical Supplier	1		IP
9T	Exempted from State EVV	2		21
9U	Medicare Advantage Plans	1		21
9V	OCDD - Point of Entry	1		21
9W	OAAS - Point of Entry	1		21
9X	OAD - Point of Entry	1		21
9Y	Juvenile Court/Drug Treatment Center	1		21
9Z	Other Contract with a State Agency	1		21
XX	Error Provider	1		XX

Appendix H

Test Plan

This appendix provides a step-by-step account of the FI's plan for testing the ASC X12N 837 COB and 835 electronic transaction sets for use in submitting encounter data for storage in the MMIS claims history file. The plan consists of three (3) tiers of testing, which are outlined in detail below.

Testing Tier I

The first step in submitter testing is enrollment performed via Molina Electronic Data Interchange (EDI) Services, Inc. Each PIHP must enroll with EDI to receive a Trading Partner ID in order to submit electronic encounter data. The PIHP will already have an ID, but are only permitted to receive electronic transactions; e.g. 834, 820, not to submit them. In this step, permission is granted for the PIHP to be able to both transmit and receive.

The second step performed concurrently with the enrollment, is EDIFECS testing. A partnership exists between EDIFECS and Molina Electronic Data Interchange (EDI) Services, Inc. to assist in compliance testing and tracking submitter test files prior to submission through the Molina Electronic Data Interchange (EDI). Certain errors will occur while testing with EDIFECS that shall not be considered when determining whether a PIHP has passed or failed the EDIFECS portion of testing.

EDI must certify each PIHP prior to the MMIS receipt of encounters via EDI. The objective is to ensure that the submitter can generate a valid X12 transaction, submit the transaction to the Molina Electronic Data Interchange (EDI), and that the transaction can be processed successfully with the resultant IRL, 997 Acceptance, or return transaction. X12 837 transactions (837I and 837P) must be in the 4010A (Addenda) format, not in the 4010 format. This phase of testing was designed to do the following:

- test connectivity with the Clearinghouse;
- validate Trading Partner IDs;
- validate the ability of the submitter to create and transmit X12 transactions with all required loops, segments, and data elements;
- validate the test submission with 997 Acceptance transactions; and
- generate IRL or paired transaction.

Once EDIFECS testing is complete, the PIHP is certified that the X12 transaction is properly formatted to submit to the MMIS. The encounter claims data from the PIHP is identified by the value ‘RP’ being present in X12 field TX-TYPE-CODE

field. The PIHP must ensure that their Medicaid IDs are in loop 2330B segment NM1 in 'Other Payer Primary Identification Number'. If line item PIHP paid amount is submitted, they also need to populate the 'Other Payer Primary Identifier' in loop 2430 segment SVD with their Medicaid provider number. These fields are used in the MMIS pre-processors to indicate that the amount in the accompanying prior paid field is the PIHP 's paid amount and not TPL or any other COB amount. For more details, please refer to the Molina Electronic Data Interchange (EDI) Services, Inc. *Submitter Testing Report* for the DHH.

Testing Tier II

Once the PIHP has successfully passed more than 50% of their encounter data claims through the pre-processors, Molina will process the encounters through the MMIS Adjudication cycle and the Payment cycle. The Payment cycle will create an 835 transaction to be retrieved by the PIHP via IDEX. Each PIHP is required to examine the returned 835s and compare them to the encounter data claims (837s) they submitted to ensure all claims that were submitted are accounted for in the data collection. Molina will send the new edit code reports to the PIHP and DHH for evaluation as well as a MMIS edit code explanation document which details the conditions under which each edit code will post to an encounter data claim in order to assist them with their research. Molina is available to answer any questions that any PIHP may have concerning the edit codes.

Testing Tier III

Once satisfactory test results are documented, Molina will move the ASC X12N 837 COB and 835 electronic transaction sets into production. Molina anticipates receiving files from the PIHP in production mode at least once monthly.

Appendix I

Websites

The following websites are provided as references for useful information not only for PIHP entities, but also for consumers, health care providers, health care organizations, and other impacted entities.

Website Address	Website Contents
http://aspe.hhs.gov/admnsimp/	This links to the **Department of Health and Human Services website regarding the Administrative Simplification provisions of HIPAA**. This site contains downloadable versions of the proposed and final rules, general information about the administrative simplification portion of the HIPAA law, an explanation of the Notice of Proposed Rulemaking (NPRM) process, update on when HIPAA standards may be implemented, and presentations made by parties regarding HIPAA.
http://www.cms.gov	This is the **CMS home page**.
http://www.wedi.org/snip/	This is the **Workgroup for Electronic Data Interchange website**. This site includes information on EDI in the health care industry, documents explaining the Privacy Rule, lists of conferences, and the availability of resources for standard transactions.
http://www.wpc-edi.com/hipaa/HIPAA_40.asp	This links to the **Washington Publishing Company website**. This site contains all the implementation guides, data conditions, and the data dictionary

Website Address	Website Contents
	(except for retail pharmacy) for X12N standards being proposed under HIPAA of 1996. They may be downloaded for free.
http://www.ansi.org	This is the **American National Standards Institute website** that allows one to download ANSI documents. You may download a copy of ANSI Procedures for the Development and Coordination of American National Standards, or a copy of ANSI Appeals Process.
http://www.x12.org	This is the **Data Interchange Standards Association website**. This site contains information on ASC X12, information on X12N subcommittees, task groups, and workgroups, including their meeting minutes. This site will contain the test conditions and results of HIPAA transactions tested at the workgroup level.
http://www.nubc.org	This is the **National Uniform Billing Committee website**. This site contains NUBC meeting minutes, activities, materials, and deliberations.
http://www.nucc.org	This is the **National Uniform Claims Committee website**. This site includes a data set identified by the NUCC for submitting non-institutional claims, encounters, and coordination of benefits. This site also includes information regarding purpose, membership, participants, and recommendations.
http://HL7.org	This site contains information on Logical Observation Identifier Names and Codes (LOINC) - **Health Level Seven (HL7)**. HL7 is being considered for requests for attachment information.

Website Address	Website Contents
http://www.cms.hhs.gov/home/medicare.asp	This is the **Medicare EDI website**. At this site, you will find information regarding Medicare EDI, advantages to using Medicare EDI, Medicare EDI formats and instructions, news and events, frequently asked questions about Medicare EDI, and information regarding Medicare paper forms and instructions.
http://www.cms.hhs.gov/medicaid/hipaa/adminsim/hipaapls.asp	This is a **monthly newsletter published by CMS's Data and System Group within the Center for Medicaid and State Operations**. It is a very good source of information for HIPAA developments. If you cannot access the website with the direct address, use http://www.cms.gov. Click on Medicaid and search using the keywords "HIPAA Plus".

Appendix J

LTC LBHP/CSoC PIHP Segment Layout

The file is a ASCII text file.

The file name is: **STOLA_MOLINA_CSOC_YYYYMMDD.TAB** (where YYYYMMDD is the date the file was created).

PART 1: PLAN FILE SUBMISSIONS

File submissions should occur each day, Monday – Friday, unless it is a holiday and then you may submit the file on the previous applicable work day.

You may submit only one file per day, so your file should contain all records that you expect to submit during that day.

If you don't have records to submit in a given day, then you should still submit a file, but it should be empty.

File submission instructions, with respect to using Molina's FTP site, will be distributed in the near future.

Plan File submission naming convention: **STOLA_MOLINA_CSOC_YYYYMMDD.TAB**

YYYYMMDD is the date of submission (Monday – Friday).

The submission file has a fixed-length record format. Each record is 117 characters in length, and uses the following record layout. As noted, specific fields are required (R) and other fields are optional (O). If a field is optional, then a value of zero(s) is acceptable, unless otherwise noted. Since we do not edit those fields, we will not produce errors based on the data in them. The file does not use delimiters and is formatted as an ASCII text file.

Field Nbr	*Column(s)*	*Field*	*Format/Length*	*R=Required O=Optional*	*Notes*
1	1-1	Record_Type	char(1)	R	1 Byte Field, Always equal to '2'.
2	2-2	Record_Sub_Type	char(1)	R	1 Byte Field, Always equal to '7'.
3	3-11	File_Sequence_No	char(9)	R	File record sequence number: The first record in the file should have number 000000001, the second 000000002, etc.
4	12-24	Recipient_ID	num(13)	R	Medicaid recipient ID
5	25-32	MEDS_Record_Seq_No	char(8)	R	The first record for a recipient should have number 00000001, the second (if present) should have 00000002, etc.
6	33-37	LTC_Waiver-Seq_No	char(5)	0	Populate with '00000'
7	38-45	Segment_Start-Date	num(8)	R	YYYYMMDD
8	46-53	Segment_Close_Date	num(8)	R	YYYYMMDD
10	54-60	LTC_Provider_Number	num(7)	R	Must be CSOC Dummy Provider, 0100867, 0101917, or 0101920
11	61-62	LTC_Waiver_Level_of_Care	char(2)	O	Segment Level of Care, populate with zeros
12	63-63	Admission_Code	char(1)	O	Segment Admission Code, populate

13	64-71	Admission_Date	num(8)	O	with zeros Segment Admission Date, populate with
14	72-79	Discharge_Date	num(8)	O	zeros Segment Discharge Date, populate with
15	80-92	PLI_Amount	num(13)	O	zeros Segment PLI Amount, populate with zeros
16	93-95	Secondary_Type_Case	char(3)	R	Must be CSOC Type Case, 200, 202, or 214
17	96-97	Secondary_Level_of_Care	char(3)	O	Segment Secondary Level of Care, populate with zeros
18	98-100	Segment_Cancel/Closure_Code	char(3)	R	Segment Closure Code, Numeric value of 000 – 999.
19	101-102	Filler	char(2)	O	Spaces
20	103-109	MEDS_LTC_Facility_Number	char(7)	O	Segment Facility No, populate with zeros
21	110-112	LTC_ Waiver_Type_Case	char(3)	O	Waiver Type Case, , populate with zeros
22	113-114	Waiver_Tempstay/Level_of_Care	char(2)	O	Temp Stay Level of Care, populate with zeros
23	115-116	State-Plan_Option	char(2)	O	State Option Plan, populate with zeros
24	117-117	End_of_Record_Marker	char(1)	R	Must be '*'

END OF RECORD LAYOUT

PART 2: SUBMISSION EDIT PROCESS

Molina will capture your file, and process it as part of the daily update processing. Molina's update process performs edits and produces a return file that includes the rejected record as sent and a status with error codes tacked onto the end of the record. Molina will also include the accepted records on the return file with a status of '00' and errors equal to '000'.

The return text file will use the naming convention: **CSOC-RETURN-YYYYMMDD.txt**

YYYYMMDD is the date from your submission file, the same date stamp used on the file sent from Magellan.

Below is the format of the return file. Required fields without notes are the fields that were sent to Molina from Magellan.

Field Nbr	***Column(s)***	***Field***	***Format/Length***	***R=Required O=Optional***	***Notes***
1	1-1	Record_Type	char(1)	R	
2	2-2	Record_Sub_Type	char(1)	R	
3	3-11	File_Sequence_No	char(9)	R	
4	12-24	Recipient_ID	num(13)	R	
5	25-32	MEDS_Record_Seq_No	char(8)	R	
6	33-37	LTC_Waiver-Seq_No	char(5)	R	
7	38-45	Segment_Start-Date	num(8)	R	
8	46-53	Segment_Close_Date	num(8)	R	
10	54-60	LTC_Provider_Number	num(7)	R	
11	61-62	LTC_Waiver_Level_of_Care	char(2)	R	
12	63-63	Admission_Code	char(1)	R	
13	64-71	Admission_Date	num(8)	R	
14	72-79	Discharge_Date	num(8)	R	
15	80-92	PLI_Amount	num(13)	R	
16	93-95	Secondary_Type_Case	char(3)	R	
17	96-97	Secondary_Level_of_Care	char(3)	R	
18	98-100	Segment_Cancel/Closure_Code	char(3)	R	
19	101-102	Filler	char(2)	R	
20	103-109	MEDS_LTC_Facility_Number	char(7)	R	
21	110-112	LTC_ Waiver_Type_Case	char(3)	R	

22	113-114	Waiver_Tempstay/Level_of_Care	char(2)	R	
23	115-116	State-Plan_Option	char(2)	R	
24	117-117	End_of_Record_Marker	char(1)	R	
25	118-119	Record_Status	char(2)	R	'00' Accepted, '01' Rejected.
26	120-123	Error-Code _1	char(3)	R	See Error Messages below.
27	124-127	Error-Code _2	char(3)	R	See Error Messages below.
28	128-131	Error-Code _3	char(3)	R	See Error Messages below.

END OF RECORD LAYOUT

Molina will perform edits that will produce the following errors.

ERROR CODES	Error Message	Error Criteria
000	No Error	No Error
001	Invalid Record Type	Set error if Record Type not = '2'.
002	Invalid Sub-Type	Set error if Sub-Type not = '7'
010	Recipient ID Must be Numeric	Set if Field is not numeric
011	Recipient ID Must be > 000000000000	Set if Field = '0000000000000'
012	Recipient ID not found on LMMIS	Set if ID is not found on LMMIS Recipient File
020	Begin Date Must be Numeric	Set if Field is not numeric
021	Begin Date Must be a Valid Date	Set if Begin Date is not a valid date (LMMIS uses standard logarithm to validate dates)
022	End Date Must be Numeric	Set if Field is not numeric
023	End Date Must be a Valid Date	Set if End Date is not a valid date (LMMIS uses standard logarithm to validate dates)
024	Begin Date Must be >= End Date	Set if Begin Date < End Date
030	Provider number not Valid CSOC Provider	Set if Provider number is not a valid CSOC Provider id. 0100867,0101917, or 0101920
031	Invalid Provider ID /Type Case	Set if the Provider ID/Type Case are not a valid CSOC pair. 0100867 - 200 0101917 - 202

		0101920 - 214
032	CSOC Eligibility cannot overlay existing Waiver	Set if the begin date matches a segment on Molina file, but that segment is not a CSOC segment. (The CSOC Provider/Type case should match when the begin date matches).
040	Secondary Type Case not a Valid CSOC Type Case	Set if Secondary Type Case is not a Valid CSOC Type Case. 200, 202, or 214
014	Invalid Cancel Code	Cancel code must be 3 byte Numeric Field. (000 – 999)

Anytime you receive a record in the edit text file with a status of '01', it indicates that the associated record in your submission file failed to update the LMMIS Recipient File. If you receive a status of '00', that record updated successfully.
Edits are applicable to required fields, we are not editing optional fields at this time. If you receive a rejected record, you may correct the issue and resubmit the record in a future submission.

END OF SECTION

Appendix K

Magellan Prior Authorization File will be sent to Molina prior to noon on the following schedule:

The file name: File Name: MGLN-PA-nnnnnnn-20151001.TXT
Where nnnnnnn is Magellan's plan's ID.

- 9-30-15: Magellan will submit a Full (all PA authorizations from 2/1/15 and forward (to-date).
- 10-25-15 : Supplemental File (any authorizations not already sent)
- 11-13-15: Supplemental File (any authorizations not already sent)
- Daily PA file from November 30 through December 14: Supplemental File (any authorizations not already sent)
- Final transfer: Medicaid requested a final PA file on December 14: Supplemental File (any authorizations not already sent)

Field Common Name	Field File Name	Field Description	Notes	Type	Data Length	Columns
Authorization MAT Number	AUTH_MAT_NUM	Magellan authorization number	Closed cases only on post-transition CRs	CHAR	9	1-9
Member Magellan ID	MEMB_MAG_ID	Magellan member identifier	Bypass cases are "999999999"	CHAR	13	10-22
Member Medicaid ID	MEMB_MED_NUM	Medicaid Recipient ID		INT	13	23-35
Member SSN	MEMB_SSN			INT	9	36-44
Member First Name	MEMB_FNAM			CHAR	15	45-59
Member Last Name	MEMB_LNAM			CHAR	25	60-84
Member Middle Initial	MEMB_MNAM			CHAR	1	85-85

Member Date of Birth	MEMB_DOB			DATE	8	86-93
Member Gender	MEMB_GENDER	M/F		CHAR	1	94-94
Facility NPI	FACIL_NPI	10-digit Provider NPI number		INT	10	95-104
Facility Tax ID	FACIL_TAXID	9-digit Tax ID		INT	9	105-113
Facility Name	FACIL_NAME			CHAR	50	114-163
Facility Address 1	FACIL_ADD1			CHAR	50	164-213
Facility Address 2	FACIL_ADD2			CHAR	50	214-263
Facility City	FACIL_CITY			CHAR	25	264-288
Facility State	FACIL_STATE			CHAR	4	289-292
Facility Zip 1	FACIL_ZIP1			INT	5	293-297
Facility Zip 2	FACIL_ZIP2			INT	4	298-301
Facility In/Out Network Status	FACIL_NET	INN/OON		CHAR	3	302-304
Provider NPI	PROVID_NPI	10-digit Provider NPI number		INT	10	305-314
Provider Tax ID	PROVID_TAXID	9-digit Tax ID		INT	9	315-323
Provider Name	PROVID_NAME			CHAR	50	324-373
Provider Address 1	PROVID_ADD1			CHAR	50	374-423
Provider Address 2	PROVID_ADD2			CHAR	50	424-473
Provider City	PROVID_CITY			CHAR	25	474-498
Provider State	PROVID_STATE			CHAR	4	499-502
Provider Zip 1	PROVID_ZIP1			INT	5	503-507
Provider Zip 2	PROVID_ZIP2			INT	4	508-511
Provider In/Out Network Statue	PROVID_NET	INN/OON		CHAR	3	512-514
Primary Diagnosis	PRIMARY_DX	ICD9/10 Code		CHAR	10	515-524
Secondary Diagnosis	SECONDARY_DX	ICD9/10 Code		CHAR	10	525-534
Tertiary Diagnosis	TERTIARY_DX	ICD9/10 Code		CHAR	10	535-544
Diagnosis Type	DIAG_TYPE	Indicates ICD9 or 10		INT	2	545-546
Level of Care	LVL_OF_CARE	Full text of Final Outcome		CHAR	50	547-596
Place of Service	PLS_OF_SVC	Full text of Place of Service		CHAR	50	597-646
Problem Type	PROB_TYPE	Full text of Problem Type		CHAR	50	647-696
Admission Date	ADMIT_DT	Initial Admission Date		DATE	8	697-704
Admission Type	ADMIT_TYPE	Urgent/Emergent/Routine		CHAR	1	705-705
Authorization Start Date	START_DT	Initial Authorization Start Date	Start date of the authorization,	DATE	8	706-713

			not necessarily this particular CR			
Authorization End Date	END_DT	Authorization End Date	Final End date of the authorization, not necessarily this particular CR	DATE	8	714-721
Closing Resolution	CLOSE_RESOL	Full text of Closing Resolution	Closed cases only on post-transition CRs	CHAR	50	722-771
Denial Reason	DENY_REASON	Full text of Denial Reason	Denials only on post-transition CRs	CHAR	50	772-821
Authorization Status	AUTH_STATUS	Authorized/Denied	Denials only on post-transition CRs	CHAR	1	822-822
Units Requested	UNIT_REQ	Units Requested in this CR		INT	3	823-825
Units Approved	UNIT_APPR	Units Approved in this CR		INT	3	826-828
CPT 1 Code	CPT1_CODE	First CPT Code of CR		CHAR	5	829-833
CPT 1 Units	CPT1_UNITS	Units for this CPT code in this CR		INT	3	834-836
CPT 1 Modifier 1	CPT1_MOD1			CHAR	2	837-838
CPT 1 Modifier 2	CPT1_MOD2			CHAR	2	839-840
CPT 2 Code	CPT2_CODE	Second CPT Code of CR		CHAR	5	841-845
CPT 2 Units	CPT2_UNITS	Units for this CPT code in this CR		INT	3	846-848
CPT 2 Modifier 1	CPT2_MOD1			CHAR	2	849-850
CPT 2 Modifier 2	CPT2_MOD2			CHAR	2	851-852
CPT 3 Code	CPT3_CODE	Third CPT Code of CR		CHAR	5	853-857
CPT 3 Units	CPT3_UNITS	Units for this CPT code in this CR		INT	3	858-860
CPT 3 Modifier 1	CPT3_MOD1			CHAR	2	861-862
CPT 3 Modifier 2	CPT3_MOD2			CHAR	2	863-864
CPT 4 Code	CPT4_CODE	Fourth CPT Code of CR		CHAR	5	865-869
CPT 4 Units	CPT4_UNITS	Units for this CPT code in this CR		INT	3	870-872
CPT 4 Modifier 1	CPT4_MOD1			CHAR	2	873-874
CPT 4 Modifier 2	CPT4_MOD2			CHAR	2	875-876

Appendix L

Provider Type – Provider Specialty – Taxonomy Crosswalk

LTX_Prov_Type	LTX_Prov_Type_Desc	LTX_Prov_Spec	LTX_Prov_Specialty_Desc	LTX_Taxonomy	LTX_Taxonomy_Desc
1	FISCAL AGENT (WVR)	4A	Developmentally Disabled (DD)	253Z00000X	Agencies In Home Supportive Care
1	FISCAL AGENT (WVR)	6H	LaPOP	253Z00000X	Agencies In Home Supportive Care
2	TRANSITIONAL SUPPORT (WVR)	4A	Developmentally Disabled (DD)	225C00000X	Respiratory, Developmental, Rehabilitative and Restorative Service Providers Rehabilitation Counselor
3	CHILDRENS CHOICE (WVR)(IN-ST)	9E	Children's Choice Waiver	101Y00000X	Behavioral Health & Social Service Providers Counselor
4	PEDI DAY HLTH CARE (IN-ST)	1Z	Pediatric Day Health Care	261QM3000X	Ambulatory Health Care Facilities Clinic/Center Medically Fragile Intants and Children Day Care

5	MANAGED CARE ORG - PREPAID	5Q		CCN-P (Coordinated Care Network, Pre-paid)	302R00000X	Managed Care Organizations Health Maintenance Organization
6	NOW PROFESSIONAL SERVICES	4B		NOW RN	163W00000X	Nursing Service Providers Registered Nurse
6	NOW PROFESSIONAL SERVICES	4C		NOW LPN	363L00000X	Physician Assistants & Advanced Practice Nursing Providers/Nurse Practitioner
6	NOW PROFESSIONAL SERVICES	4D		NOW Psychologist	103T00000X	Behavioral Health & Social Service Providers/Psychologist
6	NOW PROFESSIONAL SERVICES	4E		NOW Social Worker	104100000X	Behavioral Health & Social Service Providers Social Worker
7	CASE MGMT-INFT & TODD (IN-ST)		81	Case Management	171M00000X	Other Service Providers Case Manager/Care Coordinator
8	OAAS CASE MGMT (IN-ST)		81	Case Management	171M00000X	Other Service Providers Case Manager/Care Coordinator
9	HOSPICE SERVICES (IN-ST)		93	Hospice Service for Dual Elig.	315D00000X	Nursing & Custodial Care Facilities Hospice, Inpatient
10	COMPREHENSIVE COMM SUPPORT SRV		70	Clinic or Other Group Practice	253Z00000X	Agencies In Home Supportive Care
11	SHARED LIVING (WVR) (IN-ST)	4A		Developmentally Disabled (DD)	372600000X	Nursing Service Related Providers Adult Companion
12	MULTI-SYSTEMIC THER (IN-ST)	5M		Multi-Systemic Therapy	261QP2000X	Ambulatory Health Care Facilities Clinic/Center Physical Therapy
13	PREVOC REHAB (WVR) (IN-ST)		36	Pre-Vocational Habilitation	251C00000X	Agencies Day Training, Developmentally Disabled Services
14	DAY HABILITAT (WVR) (IN-ST)		50	Day Habilitation	261QA0600X	Ambulatory Health Care Facilities Clinic/Center Adult Day Care
15	ENVIR ACC ADAP (WVR) (IN-ST)		80	Environmental Accessibility Adaptations	171W00000X	Other Service Providers Contractor
16	PERS EMERG RESP SYS (WVR)		90	Personal Emergency Response Sys (Waiver)	333300000X	Suppliers Emergency Response System Companies

17	ASSISTIVE DEVICES (WVR)		91	Assistive Devices	225CA2400X	Respiratory, Developmental, Rehabilitative and Restorative Service Providers Rehabilitation Counselor Assistive Technology Practitioner
18	COMM MENTAL HLTH CTR/PART HOSP	5H		Community Mental Health Center	261QM0801X	Ambulatory Health Care Facilities/Clinic/Center, Mental Health
19	DR OF OSTEOPATH MED (IND & GP)		1	General Practice	208D00000X	Allopathic & Osteopathic Physicians/General Practice
19	DR OF OSTEOPATH MED (IND & GP)		2	General Surgery	208600000X	Allopathic & Osteopathic Physicians/Surgery
19	DR OF OSTEOPATH MED (IND & GP)		3	Allergy	207K00000X	Allopathic & Osteopathic Physicians/Allergy and Immunology
19	DR OF OSTEOPATH MED (IND & GP)		4	Otology, Laryngology, Rhinology	207YX0901X	Allopathic & Osteopathic Physicians/Otolaryngology/Otology & Neurotology
19	DR OF OSTEOPATH MED (IND & GP)		5	Anesthesiology	207L00000X	Allopathic & Osteopathic Physicians/Anesthesiology
19	DR OF OSTEOPATH MED (IND & GP)		6	Cardiovascular Disease	207RC0000X	Allopathic & Osteopathic Physicians/Internal Medicine, Cardiovascular Disease
19	DR OF OSTEOPATH MED (IND & GP)		7	Dermatology	207N00000X	Allopathic & Osteopathic Physicians/Dermatology
19	DR OF OSTEOPATH MED (IND & GP)		8	Family Practice	207Q00000X	Allopathic & Osteopathic Physicians/Family Medicine
19	DR OF OSTEOPATH MED (IND & GP)		9	Gynecology (DO only)	207V00000X	Allopathic & Osteopathic Physicians/Obstetrics & Gynecology

19	DR OF OSTEOPATH MED (IND & GP)		10	Gastroenterology	207RG0100X	Allopathic & Osteopathic Physicians/Internal Medicine, Gastroenterology
19	DR OF OSTEOPATH MED (IND & GP)		12	Manipulative Therapy (DO only)	207R00000X	Allopathic & Osteopathic Physicians/Internal Medicine
19	DR OF OSTEOPATH MED (IND & GP)		13	Neurology	2084N0400X	Allopathic & Osteopathic Physicians/Psychiatry and Neurology, Neurology
19	DR OF OSTEOPATH MED (IND & GP)		14	Neurological Surgery	207T00000X	Allopathic & Osteopathic Physicians/Neurological Surgery
19	DR OF OSTEOPATH MED (IND & GP)		15	Obstetrics (DO only)	207V00000X	Allopathic & Osteopathic Physicians/Obstetrics & Gynecology
19	DR OF OSTEOPATH MED (IND & GP)		16	OB/GYN	207VG0400X	Allopathic & Osteopathic Physicians/Obstetrics & Gynecology, Gynecology
19	DR OF OSTEOPATH MED (IND & GP)		17	Ophthalmology, Otology, Laryngology, Rhinology (DO only)	207W00000X	Allopathic & Osteopathic Physicians/Ophthalmology
19	DR OF OSTEOPATH MED (IND & GP)		19	Orthodontist	1223X0400X	Orthodontics and Dentofacial Orthopedics
19	DR OF OSTEOPATH MED (IND & GP)	1T		Emergency Medicine	207P00000X	Allopathic & Osteopathic Physicians/Emergency Medicine
19	DR OF OSTEOPATH MED (IND & GP)		20	Orthopedic Surgery	207X00000X	Allopathic & Osteopathic Physicians/Orthopaedic Surgery
19	DR OF OSTEOPATH MED (IND & GP)		21	Pathologic Anatomy; Clinical Pathology (DO only)	207ZP0102X	Allopathic & Osteopathic Physicians/Pathology, Anatomic Pathology & Clinical Pathology
19	DR OF OSTEOPATH MED (IND & GP)		23	Peripheral Vascular Disease or Surgery (DO only)	246XC2903X	Vascular Specialist

19	DR OF OSTEOPATH MED (IND & GP)		24	Plastic Surgery	208200000X	Allopathic & Osteopathic Physicians/Plastic Surgery
19	DR OF OSTEOPATH MED (IND & GP)		25	Physical Medicine Rehabilitation	208100000X	Allopathic & Osteopathic Physicians/Physical Medicine & Rehabilitation
19	DR OF OSTEOPATH MED (IND & GP)		26	Psychiatry	2084P0800X	Allopathic & Osteopathic Physicians/Psychiatry
19	DR OF OSTEOPATH MED (IND & GP)		27	Psychiatry; Neurology (DO only)	2084N0400X	Allopathic & Osteopathic Physicians/Psychiatry and Neurology, Neurology
19	DR OF OSTEOPATH MED (IND & GP)		28	Proctology	208C00000X	Allopathic & Osteopathic Physicians/Colon & Rectal Surgery
19	DR OF OSTEOPATH MED (IND & GP)		29	Pulmonary Diseases	207RP1001X	Allopathic & Osteopathic Physicians/Internal Medicine, Pulmonary Disease
19	DR OF OSTEOPATH MED (IND & GP)	2Q		Nuclear Medicine	207U00000X	Allopathic & Osteopathic Physicians/Nuclear Medicine
19	DR OF OSTEOPATH MED (IND & GP)		30	Radiology	2085R0202X	Allopathic & Osteopathic Physicians/Radiology, Diagnostic Radiology
19	DR OF OSTEOPATH MED (IND & GP)		31	Roentgenology, Radiology (DO only)	2085R0202X	Allopathic & Osteopathic Physicians/Radiology, Diagnostic Radiology
19	DR OF OSTEOPATH MED (IND & GP)		32	Radiation Therapy (DO only)	2085R0001X	Allopathic & Osteopathic Physicians/Radiology, Radiation Oncology
19	DR OF OSTEOPATH MED (IND & GP)		33	Thoracic Surgery	208G00000X	Allopathic & Osteopathic Physicians/Thoracic Surgery (Cardiothoracic Vascular Surgery)
19	DR OF OSTEOPATH MED (IND & GP)		34	Urology	208800000X	Allopathic & Osteopathic Physicians/Urology

19	DR OF OSTEOPATH MED (IND & GP)	37	Pediatrics	208000000X	Allopathic & Osteopathic Physicians/Pediatrics
19	DR OF OSTEOPATH MED (IND & GP)	38	Geriatrics	207QG0300X	Allopathic & Osteopathic Physicians/Family Medicine, Geriatric Medicine
19	DR OF OSTEOPATH MED (IND & GP)	39	Nephrology	207RN0300X	Allopathic & Osteopathic Physicians/Internal Medicine, Nephrology
19	DR OF OSTEOPATH MED (IND & GP)	40	Hand Surgery	207XS0106X	Allopathic & Osteopathic Physicians/Orthopaedic Surgery/Hand Surgery
19	DR OF OSTEOPATH MED (IND & GP)	41	Internal Medicine	207R00000X	Allopathic & Osteopathic Physicians/Internal Medicine
19	DR OF OSTEOPATH MED (IND & GP)	70	Clinic or Other Group Practice	193200000X	Multi-Specialty Group
20	PHYSICIAN (IND & GP)	1	General Practice	208D00000X	Allopathic & Osteopathic Physicians/General Practice
20	PHYSICIAN (IND & GP)	2	General Surgery	208600000X	Allopathic & Osteopathic Physicians/Surgery
20	PHYSICIAN (IND & GP)	3	Allergy	207K00000X	Allopathic & Osteopathic Physicians/Allergy and Immunology
20	PHYSICIAN (IND & GP)	4	Otology, Laryngology, Rhinology	207YX0901X	Allopathic & Osteopathic Physicians/Otolaryngology/Otology & Neurotology
20	PHYSICIAN (IND & GP)	5	Anesthesiology	207L00000X	Allopathic & Osteopathic Physicians/Anesthesiology
20	PHYSICIAN (IND & GP)	6	Cardiovascular Disease	207RC0000X	Allopathic & Osteopathic Physicians/Internal Medicine, Cardiovascular Disease
20	PHYSICIAN (IND & GP)	7	Dermatology	207N00000X	Allopathic & Osteopathic Physicians/Dermatology

20	PHYSICIAN (IND & GP)		8	Family Practice	207Q00000X	Allopathic & Osteopathic Physicians/Family Medicine
20	PHYSICIAN (IND & GP)		10	Gastroenterology	207RG0100X	Allopathic & Osteopathic Physicians/Internal Medicine, Gastroenterology
20	PHYSICIAN (IND & GP)		13	Neurology	2084N0400X	Allopathic & Osteopathic Physicians/Psychiatry and Neurology, Neurology
20	PHYSICIAN (IND & GP)		14	Neurological Surgery	207T00000X	Allopathic & Osteopathic Physicians/Neurological Surgery
20	PHYSICIAN (IND & GP)		16	OB/GYN	207VG0400X	Allopathic & Osteopathic Physicians/Obstetrics & Gynecology, Gynecology
20	PHYSICIAN (IND & GP)		18	Ophthalmology	207W00000X	Allopathic & Osteopathic Physicians/Ophthalmology
20	PHYSICIAN (IND & GP)		19	Orthodontist	1223X0400X	Orthodontics and Dentofacial Orthopedics
20	PHYSICIAN (IND & GP)	1T		Emergency Medicine	207P00000X	Allopathic & Osteopathic Physicians/Emergency Medicine
20	PHYSICIAN (IND & GP)		20	Orthopedic Surgery	207X00000X	Allopathic & Osteopathic Physicians/Orthopaedic Surgery
20	PHYSICIAN (IND & GP)		22	Pathology	207ZP0102X	Allopathic and Osteopathic Physicians - Pathology - Anatomic Pathology and Clinical Pathology
20	PHYSICIAN (IND & GP)		24	Plastic Surgery	208200000X	Allopathic & Osteopathic Physicians/Plastic Surgery
20	PHYSICIAN (IND & GP)		25	Physical Medicine Rehabilitation	208100000X	Allopathic & Osteopathic Physicians/Physical Medicine & Rehabilitation
20	PHYSICIAN (IND & GP)		26	Psychiatry	2084P0800X	Allopathic & Osteopathic Physicians/Psychiatry

20	PHYSICIAN (IND & GP)		28	Proctology	208C00000X	Allopathic & Osteopathic Physicians/Colon & Rectal Surgery
20	PHYSICIAN (IND & GP)		29	Pulmonary Diseases	207RP1001X	Allopathic & Osteopathic Physicians/Internal Medicine, Pulmonary Disease
20	PHYSICIAN (IND & GP)	2Q		Nuclear Medicine	207U00000X	Allopathic & Osteopathic Physicians/Nuclear Medicine
20	PHYSICIAN (IND & GP)		30	Radiology	2085R0202X	Allopathic & Osteopathic Physicians/Radiology, Diagnostic Radiology
20	PHYSICIAN (IND & GP)		33	Thoracic Surgery	208G00000X	Allopathic & Osteopathic Physicians/Thoracic Surgery (Cardiothoracic Vascular Surgery)
20	PHYSICIAN (IND & GP)		34	Urology	208800000X	Allopathic & Osteopathic Physicians/Urology
20	PHYSICIAN (IND & GP)		37	Pediatrics	208000000X	Allopathic & Osteopathic Physicians/Pediatrics
20	PHYSICIAN (IND & GP)		38	Geriatrics	207QG0300X	Allopathic & Osteopathic Physicians/Family Medicine, Geriatric Medicine
20	PHYSICIAN (IND & GP)		39	Nephrology	207RN0300X	Allopathic & Osteopathic Physicians/Internal Medicine, Nephrology
20	PHYSICIAN (IND & GP)		40	Hand Surgery	207XS0106X	Allopathic & Osteopathic Physicians/Orthopaedic Surgery/Hand Surgery
20	PHYSICIAN (IND & GP)		41	Internal Medicine	207R00000X	Allopathic & Osteopathic Physicians/Internal Medicine
20	PHYSICIAN (IND & GP)		48	Podiatry - Surgical Chiropody	213E00000X	Podiatric Medicine and Surgery Providers - Podiatrists
20	PHYSICIAN (IND & GP)		49	Miscellaneous (Admin. Medicine)	207R00000X	Allopathic & Osteopathic Physicians/Internal Medicine

20	PHYSICIAN (IND & GP)		70	Clinic or Other Group Practice	193200000X	Multi-Specialty Group
21	THIRD PARTY BILL AGT/SUBMITTER	9U		Medicare Advantage Plans	NA	NULL
21	THIRD PARTY BILL AGT/SUBMITTER	9V		OCDD - Point of Entry	NA	NULL
21	THIRD PARTY BILL AGT/SUBMITTER	9W		OAAS - Point of Entry	NA	NULL
21	THIRD PARTY BILL AGT/SUBMITTER	9X		OAD - Point of Entry	NA	NULL
21	THIRD PARTY BILL AGT/SUBMITTER	9Y		Juvenile Court/Drug Treatment Center	NA	NULL
21	THIRD PARTY BILL AGT/SUBMITTER	9Z		Other Contract with a State Agency	NA	NULL
22	PERSONAL CARE ATTENDANT (WVR)		82	Personal Care Attendant	3747P1801X	Nursing Service Related Providers Technician Personal Care Attendant
23	INDEPENDENT LAB		69	Independent Laboratory (Billing Independently)	291U00000X	Laboratories/Clinical Medical Laboratory
23	INDEPENDENT LAB		72	Diagnostic Laboratory	291U00000X	Laboratories/Clinical Medical Laboratory
24	PERSONAL CARE SERVICES (IN-ST)	5A		PCS-LTC	3747P1801X	Nursing Service Related Providers Technician Personal Care Attendant
24	PERSONAL CARE SERVICES (IN-ST)	5B		PCS-EPSDT	3747P1801X	Nursing Service Related Providers Technician Personal Care Attendant
24	PERSONAL CARE SERVICES (IN-ST)	5C		Personal Assistant Service (PAS)	3747P1801X	Nursing Service Related Providers Technician Personal Care Attendant

24	PERSONAL CARE SERVICES (IN-ST)	5D		PCS-LTC, PCS-EPSDT	3747P1801X	Nursing Service Related Providers Technician Personal Care Attendant
24	PERSONAL CARE SERVICES (IN-ST)	5E		Personal Assistant Service (PAS)	3747P1801X	Nursing Service Related Providers Technician Personal Care Attendant
24	PERSONAL CARE SERVICES (IN-ST)	5F		PCS-EPSDT, PAS	3747P1801X	Nursing Service Related Providers Technician Personal Care Attendant
24	PERSONAL CARE SERVICES (IN-ST)	5G		PCS-LTC, PCS-EPSDT, PAS	3747P1801X	Nursing Service Related Providers Technician Personal Care Attendant
25	MOBILE XRAY/RADIATION THRPY CT		63	Portable X-Ray Supplier (Billing Independently)	261QR0208X	Ambulatory Health Care Facilities/Clinic-Center, Radiology, Mammography
26	PHARMACY		87	All Other	333600000X	Suppliers/Pharmacy
27	DENTIST (IND & GP)		66	General Dentistry (DDS/DMS)	122300000X	Dental Providers Dentist
27	DENTIST (IND & GP)		67	Oral and Maxillofacial Surgery	1223S0112X	Dental Providers - Dentists - Oral and Maxillofacial Surgery
27	DENTIST (IND & GP)		68	Pediatric Dentistry	1223P0221X	Dental Providers - Dentists - Pediatric Dentistry
27	DENTIST (IND & GP)	6N		Endodontist	1223E0200X	Dental Providers - Dentists - Endodontics
27	DENTIST (IND & GP)	6P		Periodontist	1223P0300X	Dental Providers - Dentists - Periodontics
28	OPTOMETRIST (IND & GP)		88	Optician / Optometrist	152W00000X	Eye and Vision Service Providers/Optometrist
29	EARLYSTEPS (IND & GP) (IN-ST)		62	Psychologist Crossovers only	103T00000X	Behavioral Health & Social Service Providers/Psychologist
29	EARLYSTEPS (IND & GP) (IN-ST)		64	Audiologist (Billing Independently)	231H00000X	Speech, Language and Hearing Service Providers/Audiologist

29	EARLYSTEPS (IND & GP) (IN-ST)		65	Indiv Physical Therapist	225100000X	Respiratory, Developmental, Rehabilitative & Restorative Service Providers/Physical Therapist
29	EARLYSTEPS (IND & GP) (IN-ST)		71	Speech Therapy	235500000X	Speech, Language and Hearing Service Providers Specialist/Technologist
29	EARLYSTEPS (IND & GP) (IN-ST)		74	Occupational Therapy	225X00000X	Respiratory, Developmental, Rehabilitative & Restorative Service Providers/Occupational Therapist
30	CHIROPRACTOR (IND & GP)		35	Chiropractor	111N00000X	Chiropractic Providers/Chiropractor
31	PSYCHOLOGIST (LIC/MED) (IN-ST)		62	Psychologist Crossovers only	103T00000X	Behavioral Health & Social Service Providers/Psychologist
31	PSYCHOLOGIST (LIC/MED) (IN-ST)	6A		Psychologist -Clinical	103T00000X	Behavioral Health & Social Service Providers/Psychologist
31	PSYCHOLOGIST (LIC/MED) (IN-ST)	6B		Psychologist-Counseling	103T00000X	Behavioral Health & Social Service Providers/Psychologist
31	PSYCHOLOGIST (LIC/MED) (IN-ST)	6C		Psychologist - School	103T00000X	Behavioral Health & Social Service Providers/Psychologist
31	PSYCHOLOGIST (LIC/MED) (IN-ST)	6D		Psychologist - Developmental	103T00000X	Behavioral Health & Social Service Providers/Psychologist
31	PSYCHOLOGIST (LIC/MED) (IN-ST)	6E		Psychologist - Non-Declared	103T00000X	Behavioral Health & Social Service Providers/Psychologist
31	PSYCHOLOGIST (LIC/MED) (IN-ST)	6F		Psychologist - All Other	103T00000X	Behavioral Health & Social Service Providers/Psychologist
31	PSYCHOLOGIST (LIC/MED) (IN-ST)		95	Psychologist (PBS Program Only)	103T00000X	Behavioral Health & Social Service Providers/Psychologist
31	PSYCHOLOGIST (LIC/MED) (IN-ST)		96	Psychologist (PBS Program and X-Overs)	103T00000X	Behavioral Health & Social Service Providers/Psychologist

32	PODIATRIST (IND & GP)		48	Podiatry - Surgical Chiropody	213E00000X	Podiatric Medicine & Surgery Service Providers/Podiatrist
33	PRESCRIBING ONLY PROVIDER		92	PRESCRIBING ONLY PROVIDER	NA	NULL
34	AUDIOLOGIST (IN-ST)		64	Audiologist (Billing Independently)	231H00000X	Speech, Language and Hearing Service Providers/Audiologist
35	PHYSICAL THERAPIST (IN-ST)		35	Chiropractor	111N00000X	Chiropractic Providers/Chiropractor
35	PHYSICAL THERAPIST (IN-ST)		65	Indiv Physical Therapist	225100000X	Respiratory, Developmental, Rehabilitative & Restorative Service Providers/Physical Therapist
36	NOT ASSIGNED			NULL	NA	NULL
37	OCCUPATIONAL THERAPIST (IN-ST)		74	Occupational Therapy	225X00000X	Respiratory, Developmental, Rehabilitative & Restorative Service Providers/Occupational Therapist
38	SCHOOL BSED HEALTH CTR (IN-ST)	7A		SBHC - NP - Part Time - less than 20 hrs week	261Q00000X	Ambulatory Health Care Facilities Clinic/Center
38	SCHOOL BSED HEALTH CTR (IN-ST)	7B		SBHC - NP - Full Time - 20 or more hrs week	261Q00000X	Ambulatory Health Care Facilities Clinic/Center
38	SCHOOL BSED HEALTH CTR (IN-ST)	7C		SBHC - MD - Part Time - less than 20 hrs week	261Q00000X	Ambulatory Health Care Facilities Clinic/Center
38	SCHOOL BSED HEALTH CTR (IN-ST)	7D		SBHC - MD - Full Time - 20 or more hrs week	261Q00000X	Ambulatory Health Care Facilities Clinic/Center
38	SCHOOL BSED HEALTH CTR (IN-ST)	7E		SBHC - NP + MD - Part Time - total = less than 20 hrs week	261Q00000X	Ambulatory Health Care Facilities Clinic/Center
38	SCHOOL BSED HEALTH CTR (IN-ST)	7F		SBHC - NP + MD - Full Time - total = 20 or more hrs week	261Q00000X	Ambulatory Health Care Facilities Clinic/Center

39	SPEECH/LANGUAGE THERAP (IN-ST)	4W		Waiver Services	235500000X	Speech, Language and Hearing Service Providers Specialist/Technologist
39	SPEECH/LANGUAGE THERAP (IN-ST)		71	Speech Therapy	235500000X	Speech, Language and Hearing Service Providers Specialist/Technologist
40	DME	2Y		OPH Genetic Disease Program	332B00000X	Suppliers/Durable Medical Equipment & Medical Supplies
40	DME		51	Med Supply / Certified Orthotist	332B00000X	Suppliers/Durable Medical Equipment & Medical Supplies
40	DME		52	Med Supply / Certified Prosthetist	332B00000X	Suppliers/Durable Medical Equipment & Medical Supplies
40	DME		53	Direct Care Worker	332B00000X	Suppliers/Durable Medical Equipment & Medical Supplies
40	DME		54	Med Supply / Not Included in 51, 52, 53	332B00000X	Suppliers/Durable Medical Equipment & Medical Supplies
40	DME		55	Indiv Certified Orthotist	332B00000X	Suppliers/Durable Medical Equipment & Medical Supplies
40	DME		56	Indiv Certified Prosthetist	332B00000X	Suppliers/Durable Medical Equipment & Medical Supplies
40	DME		57	Indiv Certified Prosthetist - Orthotist	332B00000X	Suppliers/Durable Medical Equipment & Medical Supplies
40	DME		58	Indiv Not Included in 55, 56, 57	332B00000X	Suppliers/Durable Medical Equipment & Medical Supplies
40	DME		87	All Other	332B00000X	Suppliers/Durable Medical Equipment & Medical Supplies
41	REGISTERED DIETICIAN (IN-ST)	4R		Registered Dietician	133V00000X	Dietary & Nutritional Service Providers/Dietician, Registered
42	NON-EMER MED TRANSPORT (IN-ST)		45	NEMT - Non-profit	343900000X	Transportation Services Non-emergency Medical Transport (VAN)

42	NON-EMER MED TRANSPORT (IN-ST)		46	NEMT - Profit	343900000X	Transportation Services Non-emergency Medical Transport (VAN)
42	NON-EMER MED TRANSPORT (IN-ST)		47	NEMT - F+F	343900000X	Transportation Services Non-emergency Medical Transport (VAN)
42	NON-EMER MED TRANSPORT (IN-ST)	4W		Waiver Services	343900000X	Transportation Services Non-emergency Medical Transport (VAN)
42	NON-EMER MED TRANSPORT (IN-ST)	4X		Waiver-Only Transportation	343900000X	Transportation Services Non-emergency Medical Transport (VAN)
43	CASE MGT - NHV/FTM (IN-ST)		81	Case Management	163WC0400X	Nursing Service Providers Registered Nurse Case Management
44	HOME HEALTH AGENCY (IN-ST)		87	All Other	251E00000X	Agencies/Home Health
45	CASE MGMT - CONTRACTOR (IN-ST)		81	Case Management	171M00000X	Other Service Providers Case Manager/Care Coordinator
46	CASE MGMT - HIV		81	Case Management	171M00000X	Other Service Providers Case Manager/Care Coordinator
47	CASE MGMT - CMI		81	Case Management	171M00000X	Other Service Providers Case Manager/Care Coordinator
48	CASE MGMT - PREGNANT WOMEN		81	Case Management	171M00000X	Other Service Providers Case Manager/Care Coordinator
49	CASE MGMT - DEVELOP DISABLED		81	Case Management	171M00000X	Other Service Providers Case Manager/Care Coordinator
50	PACE (ALL-INCLUSIVE CARE-ELD)	5P		PACE	251T00000X	Agencies PACE Provider Organization
51	AMBULANCE TRANSPORTATION		59	Ambulance Service Supplier, Private	341600000X	Transportation Services/Ambulance

52	CO-ORDIN CARE NETWORK-SHARED SELF	5R	CCN-S (Coordinated Care Network, Shared Savings)	302R00000X	Managed Care Organizations Health Maintenance Organization	
53	DIRECTED/DIRECT SUPPORT		NULL	172V00000X	Other Service Providers Community Health Worker	
54	AMBULATORY SURGI CTR (IN-ST)	70	Clinic or Other Group Practice	261QA1903X	Ambulatory Health Care Facilities/Clinic-Center, Ambulatory Surgical	
55	EMERG ACCESS HOSPITAL (IN-ST)	86	Hospitals and Nursing Homes	261QC0050X	Ambulatory Health Care Facilities Clinic/Center Critical Access Hospital	
56	PRESCRIBER ONLY FOR MCO		NULL	NA	NULL	
57	OPH REGISTERED NURSE (IN-ST)	60	Public Health or Welfare Agencies & Clinics	163W00000X	Nursing Service Providers Registered Nurse	
58	NOT ASSIGNED		NULL	NA	NULL	
59	NEURO REHAB HOSPITAL (IN-ST)	86	Hospitals and Nursing Homes	273Y00000X	Hospital Units/Rehabilitation Unit	
60	HOSPITAL	85	Extended Care Hospital	282N00000X	Hospitals/General Acute Care Hospital	
60	HOSPITAL	86	Hospitals and Nursing Homes	282N00000X	Hospitals/General Acute Care Hospital	
60	HOSPITAL	87	All Other	282N00000X	Hospitals/General Acute Care Hospital	
61	VENERIAL DISEASE CL (IN-ST)	60	Public Health or Welfare Agencies & Clinics	261Q00000X	Ambulatory Health Care Facilities Clinic/Center	
62	TUBERCULOSIS CLINIC	60	Public Health or Welfare Agencies & Clinics	261Q00000X	Ambulatory Health Care Facilities Clinic/Center	
63	TUBERCULOSIS INPT HOSPITAL		NULL	NA	NULL	

64	MENTAL HLTH HOSP (FREE-STAND)		86	Hospitals and Nursing Homes	283Q00000X	Hospitals/Psychiatric Hospital
65	REHABILITATION CENTER (IN-ST)		75	Other Medical Care	261QR0400X	Ambulatory Health Care Facilities/Clinic/Center, Rehabilitation
66	KIDMED SCREENING CLINIC		44	Public Health/EPSDT	261Q00000X	Ambulatory Health Care Facilities Clinic/Center
66	KIDMED SCREENING CLINIC		60	Public Health or Welfare Agencies & Clinics	261Q00000X	Ambulatory Health Care Facilities Clinic/Center
67	PRENATAL HLTH CARE CL (IN-ST)		60	Public Health or Welfare Agencies & Clinics	261QP2300X	Ambulatory Health Care Facilities Clinic/Center Primary Care
68	SUBS/ALCOH ABSE CTR (X-OVERS)	5N		Substance Abuse and Alcohol Abuse Center	324500000X	Residential Treatment Facilities Substance Abuse Rehabilitation Facility
68	SUBS/ALCOH ABSE CTR (X-OVERS)		70	Clinic or Other Group Practice	324500000X	Residential Treatment Facilities Substance Abuse Rehabilitation Facility
69	DIST PART PSYCH HOSP (IN-ST)		86	Hospitals and Nursing Homes	283Q00000X	Hospitals/Psychiatric Hospital
70	EPSDT HEALTH SERVICES (IN-ST)		44	Public Health/EPSDT	251300000X	Agencies Local Education Agency (LEA)
71	FMLY PLANNING CLINIC (IN-ST)		97	Family Planning Clinic	261QF0050X	Ambulatory Health Care Facilities Clinic/Center Family Planning, Non-Surgical
72	FED QUALIFIED HLTH CTR (IN-ST)		42	Federally Qualified Health Centers	261QF0400X	Ambulatory Health Care Facilities/Federally Qualified Health Center (FQHC)
72	FED QUALIFIED HLTH CTR (IN-ST)	9L		RHC/FQHC OPH Certified SBHC	261QF0400X	Ambulatory Health Care Facilities/Federally Qualified Health Center (FQHC)
73	LIC CL SOCIAL WORKER (IN-ST)		73	Social Worker Enrollment	104100000X	Behavioral Health & Social Service Providers Social Worker

74	MENTAL HEALTH CLINIC (IN-ST)	70	Clinic or Other Group Practice	261QM0801X	Ambulatory Health Care Facilities/Clinic/Center, Mental Health
75	OPTICAL SUPPLIER	88	Optician / Optometrist	332H00000X	Suppliers Eyewear Supplier (Equipment, not the service)
76	HEMODIALYSIS CENTER (IN-ST)	70	Clinic or Other Group Practice	261QE0700X	Ambulatory Health Care Facilities/End-Stage Renal Disease (ESRD) Treatment
77	MENTAL REHAB AGENCY (IN-ST)	78	Mental Health Rehab	103TR0400X	Behavioral Health & Social Service Providers/Psychologist, Rehabilitation
78	NURSE PRACTITIONER (IND & GP)	8	Family Practice	363LF0000X	Physician Assistants and Advanced Practice Nursing Providers - Nurse Practitioner - Family
78	NURSE PRACTITIONER (IND & GP)	16	OB/GYN	363LX0001X	Physician Assistants and Advanced Practice Nursing Providers - Nurse Practitioner - Obstetrics & Gynecology
78	NURSE PRACTITIONER (IND & GP)	26	Psychiatry	364SP0808X	Physician Assistants & Advanced Practice Nursing Providers/Clinical Nurse Specialist, Psychiatric/Mental Health
78	NURSE PRACTITIONER (IND & GP)	37	Pediatrics	363LP0200X	Physician Assistants and Advanced Practice Nursing Providers - Nurse Practitioner - Pediatrics
78	NURSE PRACTITIONER (IND & GP)	79	Nurse Practitioner	363L00000X	Physician Assistants & Advanced Practice Nursing Providers/Nurse Practitioner
79	RURAL HLTH CL(PROV-BSE)(IN-ST)	94	Rural Health Clinic	261QR1300X	Ambulatory Health Care Facilities/Clinic/Center, Rural Health

80	NURSING FACILITY (IN-ST)		86	Hospitals and Nursing Homes	314000000X	Nursing and Custodial Care Facilities/Skilled Nursing Facility
81	CASE MGMT - VENT ASSTD CARE		81	Case Management	171M00000X	Other Service Providers Case Manager/Care Coordinator
82	PERS CARE ATTEND (WVR) (IN-ST)		82	Personal Care Attendant	3747P1801X	Nursing Service Related Providers Technician Personal Care Attendant
82	PERS CARE ATTEND (WVR) (IN-ST)	8D		Community Choices Waiver - Caregiver Temporary Support	3747P1801X	Nursing Service Related Providers Technician Personal Care Attendant
83	CTR BASED RESPITE CARE (IN-ST)		83	Respite Care	385H00000X	Respite Care Facility Respite Care
83	CTR BASED RESPITE CARE (IN-ST)	8D		Community Choices Waiver - Caregiver Temporary Support	385H00000X	Respite Care Facility Respite Care
84	SUBSTIT FMLY CARE (WVR)(IN-ST)		84	Substitute Family Care	106H00000X	Behavioral Health & Social Service Providers Marriage & Family Therapist
85	ADLT DAY HLTH CA (WVR) (IN-ST)		76	Adult Day Care	261QA0600X	Ambulatory Health Care Facilities Clinic/Center Adult Day Care
85	ADLT DAY HLTH CA (WVR) (IN-ST)		77	Habilitation	261QA0600X	Ambulatory Health Care Facilities Clinic/Center Adult Day Care
86	ICF/DD REHABILITATION			NULL	261QR0400X	Ambulatory Health Care Facilities/Clinic/Center, Rehabilitation
87	RURAL HLTH CL(INDEPEND)(IN-ST)		94	Rural Health Clinic	261QR1300X	Ambulatory Health Care Facilities/Clinic/Center, Rural Health
88	ICF/DD - GROUP HOME (IN-ST)		86	Hospitals and Nursing Homes	261QD1600X	Ambulatory Health Care Facilities Clinic/Center Developmental Disabilities

89	SPRVISE INDEP LIV (WVR)(IN-ST)		89	Supervised Independent Living	372600000X	Nursing Service Related Providers Adult Companion
90	CERTIFIED NURSE MIDWIFE		16	OB/GYN	367A00000X	Physician Assistants & Advanced Practice Nursing Providers/Midwife, Certified Nurse
91	CERT REG NURS ANEST (IND & GP)		5	Anesthesiology	163W00000X	Nursing Service Providers Registered Nurse
91	CERT REG NURS ANEST (IND & GP)		70	Clinic or Other Group Practice	163W00000X	Nursing Service Providers Registered Nurse
92	PRIVATE DUTY NURSE			NULL	NA	NULL
93	CLINICAL NURSE SPECIALIST		2	General Surgery	364S00000X	Physician Assistants & Advanced Practice Nursing Providers/Clinical Nurse Specialist
93	CLINICAL NURSE SPECIALIST		26	Psychiatry	364S00000X	Physician Assistants & Advanced Practice Nursing Providers/Clinical Nurse Specialist
94	PHYSICIAN ASSISTANT		26	Psychiatry	364SP0808X	Physician Assistants & Advanced Practice Nursing Providers/Clinical Nurse Specialist, Psychiatric/Mental Health
94	PHYSICIAN ASSISTANT	2R		Physician Assistant	363A00000X	Physician Assistants & Advanced Practice Nursing Providers/Physician Assistant
95	AMERICAN INDIAN/638 FACILITY	2T		American Indian / Native Alaskan	332800000X	Suppliers Indian Health Service/Tribal/Urban Indian Health (I/T/U) Pharmacy
96	PSYCH RESID TREAT FACILITY	8L		Hospital-based PRTF	323P00000X	Residential Treatment Facilities Psychiatric Residential Treatment Facility

96	PSYCH RESID TREAT FACILITY	8P	IP - Physician - MD	323P00000X	Residential Treatment Facilities Psychiatric Residential Treatment Facility
96	PSYCH RESID TREAT FACILITY	9B	Psychiatric Residential Treatment Facility	323P00000X	Residential Treatment Facilities Psychiatric Residential Treatment Facility
97	ADULT RESIDENTIAL CARE FAC	9D	Residential Care	3747P1801X	Nursing Service Related Providers Technician Personal Care Attendant
98	SUPPORTED EMPLYMENT (IN-ST)	98	Supported Employment	251C00000X	Agencies Day Training, Developmentally Disabled Services
99	GREAT NO COMM HLTH CONN(IN-ST)	9P	GNOCHC - Greater New Orleans Community Health Connection	251K00000X	Agencies/Public Health or Welfare
AA	ASSERTIVE COMM TREAT TEAM		NULL	261QC1500X	Ambulatory Health Care Facilities Clinic/Center Community Health
AB	PREPAID INPATIENT HLTH PLAN	5I	Statewide Management Organization (SMO)	305R00000X	Managed Care Organizations Preferred Provider Organization
AC	FAMILY SUPPORT ORGANIZATION	5J	Youth Support	364SF0001X	Physician Assistants & Advanced Practice Nursing Providers/Clinical Nurse Specialist, Family Health
AC	FAMILY SUPPORT ORGANIZATION	5K	Family Support	364SF0001X	Physician Assistants & Advanced Practice Nursing Providers/Clinical Nurse Specialist, Family Health
AC	FAMILY SUPPORT ORGANIZATION	5L	Both Youth and Family Support	364SF0001X	Physician Assistants & Advanced Practice Nursing Providers/Clinical Nurse Specialist, Family Health
AD	TRANSITION COORDINATION	5U	Individual	251C00000X	Agencies Day Training, Developmentally Disabled Services
AD	TRANSITION COORDINATION	5V	Agency/Business	251C00000X	Agencies Day Training, Developmentally Disabled Services

AE	RESPITE CARE SERVICE AGENCY		83	Respite Care	385H00000X	Respite Care Facility Respite Care
AF	CRISIS RECEIVING CENTER	8E		CSoC/Behavioral Health	261Q00000X	Ambulatory Health Care Facilities Clinic/Center
AG	BEHAVIORAL HLTH REHAB AGENCY	8E		CSoC/Behavioral Health	251S00000X	Agencies Community/Behavioral Health
AH	LIC MARRIAGE & FAMILY THERAPY	8E		CSoC/Behavioral Health	106H00000X	Behavioral Health & Social Service Providers Marriage & Family Therapist
AJ	LICENSED ADDICTION COUNSELOR	8E		CSoC/Behavioral Health	101YA0400X	Behavioral Health & Social Service Providers Counselor Addiction (Substance Use Disorder)
AK	LICENSED PROFESSION COUNSELOR	8E		CSoC/Behavioral Health	101YP2500X	Behavioral Health & Social Service Providers Counselor Professional
AL	COMMUNITY CHOICE WAIVER-NURS	8K		ADHC HCBS	251K00000X	Agencies/Public Health or Welfare
AM	HOME DELIVERED MEALS	8M		Community Choices Waiver - Home-Delivered Meals	174200000X	Other Service Providers Meals
AN	CAREGIVER TEMPORARY SUPPORT	8D		Community Choices Waiver - Caregiver Temporary Support	3747P1801X	Nursing Service Related Providers Technician Personal Care Attendant
AN	CAREGIVER TEMPORARY SUPPORT	8H		Community Choices Waiver - Caregiver Temporary Support - ADHC	3747P1801X	Nursing Service Related Providers Technician Personal Care Attendant
AQ	NON-MEDICAL GROUP HOME	9G		Non-Medical Group Home (NMGH)	NA	NULL

AR	THERAPEUTIC FOSTER CARE	9F		Therapeutic Foster Care (TFC)	3747P1801X	Nursing Service Related Providers Technician Personal Care Attendant
AS	OPH CLINIC		70	Clinic or Other Group Practice	261QP0905X	Ambulatory Health Care Facilities Clinic/Center Public Health, State or Local
AU	OPH REGISTERED DIETITIAN	4U		OPH Registered Dietitian	133V00000X	Dietary & Nutritional Service Providers/Dietician, Registered
AV	EXTENDED DUTY DENTAL ASSISTANT	3X		Extended Duty Dental Assistant	126800000X	Dental Providers Dental Assistant
AW	PERMANENT SUPPOR HOUSING AGENT	3W		Supportive Housing Agency	NA	NULL
AX	CERTIFIED BEHAVIOR ANALYST	6U		Applied Behavioral Analyst	103K00000X	Behavioral Health & Social Service Providers Behavioral Analyst
IP	EHR INCENTIVE PROGRAM	IP		NULL	NA	NULL
XX	ERROR PROVIDER	XX		Error Provider	NA	NULL

END OF SECTION

Prepaid Inpatient Health Plan (PIHP) Coordinated System of Care (CSoC) Systems Companion Guide